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STATE HEALTH CARE PLANS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

ON

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COMMUNICATIONS

STATE HEALTH CARE PLANS

WEDNESDAY, SEPTEMBER 9, 1992

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:25, in room SD–215, Dirksen Senate Office Building, Hon. Lloyd Bentsen (chairman of the committee) presiding.

Also present: Senators Moynihan, Baucus, Mitchell, Pryor, Riegle, Rockefeller, Daschle, Packwood, Chafee, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H–45, Sept. 3, 1992]

BENTSEN CALLS HEARING ON STATE HEALTH CARE PLANS; FOUR GOVERNORS TO DISCUSS PROPOSALS

WASHINGTON, DC—Senator Lloyd Bentsen, Chairman of the Senate Finance Committee, Thursday announced four Governors are expected to testify on allowing states to implement their own health care reforms.

The hearing will be at *10 a.m., Wednesday, September 9, 1992* in Room SD–215 of the Dirksen Senate Office Building.

Governors Lawton Chiles of Florida, Howard Dean of Vermont, George Mickelson of South Dakota and Roy Romer of Colorado are scheduled to testify.

"A number of states are ready to move forward with statewide health care reform plans. But some of these plans cannot be fully implemented without changes in Federal law. I applaud state efforts to reduce the number of uninsured Americans. Several proposals have been made to change Federal policies to enable states to move forward, and we need to take a careful look at them," Bentsen said.

"I look forward to hearing the views of these Governors and other witnesses on how Federal law can be changed to make it easier for states to implement health care plans," Bentsen said.

OPENING STATEMENT OF HON. LLOYD BENTSEN, A U.S. SENATOR FROM TEXAS, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The purpose of today's hearing is to examine the critical issues of how Congress can help the States to ensure universal access to health care.

It is really unconscionable that we have nearly 35 million Americans who lack health insurance. A quarter of those are children.

We find that the infant mortality in some U.S. cities rivals that of Third World countries, and that due to the lack of portability of insurance benefits, three out of 10 people report that they have someone in their family who has been unable to change jobs, even though a better job is offered, because they will not have the health insurance benefits, or they have some preexisting condition for themselves or a member of their family. All of us know cases like that.

Earlier this year, this committee and the Senate approved S. 1872, the Better Access bill, which Senator Durenberger and I introduced last year. That bill now has 26 other co-sponsors, and 10 of them who are members of this committee.

The purpose of the bill, which is waiting action by the House, is to begin the process of reforming the health care system.

In addition, I continue to believe that it is important for the administration and the Congress to work together to develop a serious and enactable comprehensive health care reform bill, but I think everyone here today realizes how challenging and time-consuming that task will be.

Several States are very ready to take action now. Under the bold leadership of their Governors, these States are ready to commit themselves to ensuring that all their residents have access to affordable health insurance.

I certainly recognize the difference in cost conditions for the various States, and the reason for giving them additional latitude in the way of initiating those kinds of studies.

I am pleased to welcome some of these Governors to Washington this morning: the Governor of Colorado, Roy Romer; the Governor of Vermont, Dr. Howard Dean; the Governor of South Carolina, George Mickelson; and the Governor of Florida, our former colleague, Governor Lawton Chiles.

These distinguished witnesses will share their ideas for providing health care coverage and containing health care costs, and explain why they need changes in Federal law to carry out their State plans.

Our colleague, Senator Akaka, will testify about the success story in his State of Hawaii, where fewer than 10 percent of the residents are uninsured, compared to other States, such as my own, where up to 26 percent are uninsured.

Another colleague, Senator Leahy, from Vermont, will also testify today about the bill that he and Senator Pryor have developed to help States move forward with health care reform by providing for waivers of certain aspects of the Federal ERISA Medicaid and Medicare laws.

Also with us today are, Robert Stone, representing the ERISA Industry Committee; and Karen Ignagni, representing the AFL–CIO. They will discuss the impact on business and labor of the changes proposed in the Leahy-Pryor bill.

Tim Riles, the insurance commissioner for the State of Georgia, will present the perspectives of the National Association of Insurance Commissioners.

Finally, Joseph Liu, of the Children's Defense Fund, and Judy Waxman, of Families USA, will provide the consumer perspective on both the Leahy-Pryor bill, and the Medicaid Managed Care Proposal developed by Senators Moynihan and Durenberger.

The issues to be discussed today are extremely important. In my view, the Governors testifying before us and their colleagues in the States across the country deserve congratulations for their efforts.

At the same time, Congress has a responsibility to move with care in amending the ERISA, Medicare, and Medicaid statutes. These provisions were designed to protect American workers, the elderly, the disabled, and low-income families.

I think one of the first major pieces of legislation I was seriously involved in was on this committee, as chairman of the pension subcommittee, that brought ERISA through this committee.

Our colleagues who have developed the legislation under discussion today have made every effort to strike the proper balance between flexibility and Congressional responsibility.

I look forward to hearing the views of today's witnesses, and to working with the Governors, the business community, and organized labor to move toward the goal that we all share: affordable health care for every American.

I would like to call, now, on Senator Durenberger. Would you care to make a statement?

OPENING STATEMENT OF HON. DAVE DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Yes, Mr. Chairman. I have about a six-page statement I will ask be made a part of the record.

The CHAIRMAN. That will be done.

[The prepared statement of Senator Durenberger appears in the appendix.]

Senator DURENBERGER. I want to make just two basic observations. One, is that all of the sinners, I think, are at this table, as well as all of the confessors, if you will. Because if the problem here is the uninsured, the cause is our inability to deal with the high cost of medical care.

The issue before us is, what role do State governments play, and what role do employers play in solving that problem? Up till now, the problem has been created by State governments, by the Federal Government, by a lot of other government entities, and has been created by employers.

The fully-paid subsidies for employer-based health insurance have created, in large part, the problem that we are trying to address in high cost.

The barrier that we are talking about today—ERISA—to the self-insureds carrying their fair share of the load is used to keep people who are trying to do something about health care protection, save them from the mandates being imposed on them by the Governors before us, and by the State Legislatures.

There is no question but the fact that 800 mandated provider benefits brought to us through the State Legislatures through the courtesy of all of the doctors in the country, all of the chiropractors in the country, all of the facial reconstruction specialists in the country, have had a whole lot to do with why the self-insured employers in this country are hanging onto their ERISA preemption.

The good news, however, is all that has changed. The employers are now trying to do the right thing; trying to use their purchasing power in the marketplace to change doctor behavior for the better, change hospital behavior for the better, change their employee behavior for the better.

State Governments, absent any action on our part, are trying to move to close the gap of the uninsured to stop the cost shifting onto the insured company. So, I wanted to start with the observation that we have all been sinners in this. I think we are all recently converted.

And the question before us will be, how best to make both employers and employment-based health insurance work to expand access to the 51 percent of the people in that uninsured market that have a job, and how best to use State action, in the absence of Federal action, to accomplish it.

There will be two approaches before us; they do not differ by that much. My colleagues, Pat Leahy, who is going to speak now, and Dave Pryor, have one approach. I have another approach I will introduce tomorrow. I have already got a number of co-sponsors on it, and many of whom are co-sponsoring the other approach.

The basic difference in our approach is simply this. Their approach, in effect, sets up a regulatory process, if you will, for determining under what circumstances States' cost containment programs will qualify to add some financial burden to employer markets. Mine does not get into that. Mine simply says that if the State, in fact, deals with the issues of small group insurance reform, expanding coverage, dealing with the problems of managed care, and starts moving in that direction, that however they approach it, whether they approach it through producer taxes, or premium taxes, or whatever, those taxes should not be borne by this dwindling number of people who are not self-insured. It should be borne by every covered person in the State.

I think either of those approaches, Mr. Chairman, would be helpful to both sides. The one that I suggest, I think, probably would be least burdensome to those that we will hear today that do not want to see ERISA preemption changed in any way.

The CHAIRMAN. Thank you. Senator Baucus, for any comments you might care to make.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman. I have a statement which I would like to include in the record.

The CHAIRMAN. Without objection, that will be done.

[The prepared statement of Senator Baucus appears in the appendix.]

Senator BAUCUS. Very briefly, I would just like to say that health care in the State of Montana is as much the number one issue as it is, I think, in other States in the Nation.

To that end, I have appointed a group in my State, chaired by the Dean of the law school of the University of Montana, Martin Burke; the Dean of the Pharmacy School at the University of Montana, David Forbes, and also the dean of the College of Nursing at Montana State University, Kathleen Long, members of the commission represent people from across the board in my State.

We are doing all we can to develop recommendations for the State legislature and for our new Governor by next January in order to enact statewide comprehensive health care reform.

Health care cost is the fastest-growing item in the State's budget. Twenty percent of Montanans are uninsured. We have also, I think, the largest under-insured proportions of people in our State, and it is a very, very great problem that we all face. I hope that either the bill sponsored by Senator Leahy, from Vermont, or Sen-

ator Durenberger, or some combination, will be passed, and very quickly.

I believe that States should be the laboratories to help us in Congress fashion a national health care reform bill. I do not think we know all the answers here in Congress. We certainly do not yet.

Different States are different, and different State experiences will help us and the Congress know how to fashion the correct bill. I urge us to pass the kind of legislation that we are now dealing with so that States can go ahead and enact meaningful comprehensive health care reform. Thank you.

The CHAIRMAN. Senator Riegle, for any comments you might want to make.

OPENING STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM MICHIGAN

Senator RIEGLE. Thank you. We have got a number of witnesses, so I, too, will make my statement a part of the record.

The CHAIRMAN. Without objection, that will be done.

[The prepared statement of Senator Riegle appears in the appendix.]

Senator RIEGLE. I want to commend Senator Leahy and Senator Pryor for their leadership on S. 3180, which we are here to look at today. I, among others, am a co-sponsor of that legislation.

Now, I think there are some refinements that we need to make, and we will be discussing those; one, in the area of ERISA, which the chairman has mentioned.

I also want to commend the Governors who are here today for the leadership that they are taking in the absence of a comprehensive national health insurance program for the country as a whole. Clearly, that is what is needed.

But, in the absence of that, until that is done, the States are under tremendous financial pressure, and tremendous pressure with respect to meeting the health needs of their people.

And I think that we have to help them do that at the same time we push very hard for a comprehensive national health insurance plan that both controls costs and guarantees access.

Finally, I want to stress also the important testimony we took from the Governor of Hawaii when he was here before the Subcommittee on Health for Families and the Uninsured not long ago—June 15. Senator Akaka, I know, is going to testify about the Hawaiian experience.

It is very easy for us, I think, in the other States far removed from Hawaii to not understand the fact that now, for 18 years, they have had a comprehensive health insurance plan in place through people's place of employment. And they not only have managed to solve the problem of access, but they have actually managed to get health care costs down.

Their health profile in terms of their citizenry is not substantially different from the rest of the country. We have a working model now that is some 20 years old that is giving us all of the positive results that we talk about wanting to achieve.

So, I think it is very important that we take a much more careful look at the Hawaiian experience because I think it can guide us in our discussion today. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Chafee, any comments you might want to make.

OPENING STATEMENT OF HON. JOHN H. CHAFEE, A U.S. SENATOR FROM RHODE ISLAND

Senator CHAFEE. Thank you, Mr. Chairman. First of all, I want to say I am very glad you are holding this hearing, and I look forward to it.

Last November, which was some 10 months ago, along with some 23 other Members of the Senate, I introduced legislation to reform key components of our health care system.

And in that was a provision to allow the States to apply for waivers of Federal programs to enact statewide health care reform. That bill was S. 1936. It is a little bit different from the one that Senators Leahy and Pryor have, although I am a co-sponsor of that legislation, as well.

My bill did not have a limitation on the number of States; theirs has 10. Also, I provided for waivers in Medicare and Medicaid, as they do, and ERISA. But, also, I went a little further. Or we did. It is not just I, it is we. As I say, there are some 23 Senators that are on that bill, which has more co-sponsors than any health care legislation in the Senate.

I provided for the fact that it could deal with public health programs and VA programs, as well. I am also a co-sponsor of the one Senator Durenberger is going to put in tomorrow.

Mr. Chairman, I think the point here is that there is a lot of similarity between what the Republicans are attempting to achieve and what the Democrats are attempting to achieve in health care reform.

And, for the life of me, I cannot understand why we cannot move forward in this Congress with the points that are common to these various programs and get them done this year.

You know, there has been a lot of talk about gridlock in this Congress and there is no question that there has been gridlock. And I, for one, find it very, very difficult, as I say, to understand why we just do not agree on the points we can agree upon and move forward.

Insurance market reform; everybody is for that. Preemption of the costly State-mandated benefits; everybody is for that. The waivers, as we mentioned before; the medical liability reform encouraging managed care; encouraging the formation of group purchasing organizations; administrative reform.

These are some of the points of commonality that we could just go forward with if we could get over the obstacles of those who want a comprehensive reform and reject the ability to move forward with these 11-some points that I have mentioned previously.

And what we are going to do, Mr. Chairman, if everybody stands their ground firmly looking for this comprehensive total reform, is to get nowhere the way we have gotten nowhere over the past 20 years.

So, Mr. Chairman, I am hopeful that Congress will enact this and other reforms this year, and I commend those who have been active in it. I want to do everything I can to be helpful. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Senator Daschle, for any comments you might make.

OPENING STATEMENT OF HON. TOM DASCHLE, A U.S. SENATOR FROM SOUTH DAKOTA

Senator DASCHLE. Thank you, Mr. Chairman. I, too, would like to commend you for holding this hearing, and commend our colleagues, Senators Leahy and Pryor, for introducing this legislation.

We cannot afford to go nowhere, as Senator Chafee has indicated. We have got to go somewhere with health care reform, and I believe that this legislation is a real contribution to that effort.

I have co-sponsored this bill because I believe it contains some of the same features that Senator Wofford and I, and others who have co-sponsored my legislation, believe is essential to an effective national health care reform plan.

I think that, whatever type of reform plan we enact, it has got to be a State-based system. A State-based system gives us the kind of local accountability that we so desperately need as we deal with the hundreds of billions of dollars in our health care system.

It provides us with innovation. States can provide workshop opportunities. We have seen that in Hawaii, as Senator Riegle has indicated; we have seen it in Oregon; we have recently seen it in Minnesota.

There is no better opportunity for us to use States as innovative workshops to address issues confronting different parts of the country than proposals that allow for State-based differences.

Third, I think our health care delivery system has to be much more responsive, and State-based systems like the Leahy-Pryor bill will allow for that. There has got to be a lot more sensitivity to the differences that exist between New York and South Dakota.

And, finally, I think you can argue a State-based system will reduce costs. Certainly, in this approach, as well as in the one Senator Wofford and I are advocating, there are very clear mechanisms by which we can reduce administrative costs, reduce the tremendous costs associated with bureaucracy and the delivery of the health care in this country.

So, I think this bill offers a very positive contribution to the debate. I am pleased to see their leadership and I am very hopeful that this hearing can provide us with some good answers. I thank you, Mr. Chairman.

The CHAIRMAN. Senator Rockefeller.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER IV, A U.S. SENATOR FROM WEST VIRGINIA

Senator ROCKEFELLER. Mr. Chairman, I submit my statement for the record.

The CHAIRMAN. Without objection, that will be done.

[The prepared statement of Senator Rockefeller appears in the appendix.]

Senator ROCKEFELLER. I would point out that I think that States have a lot to offer in terms of not only what they are doing, but, frankly, the pressure they put on us. They have taken the leadership in the past.

I would remind our colleagues that the Medicare DRG system, obviously, which is Federal at this point, was designed after an experiment that took place in the State of New Jersey.

And, it was the States who were the first ones to recognize the need to decouple Medicaid eligibility for welfare. States have a lot to offer. I thank the Chair.

The CHAIRMAN. Thank you very much. I see we have another vote coming up. I was interested in my friend from Rhode Island's comment about his co-sponsors, because the Bentsen-Durenberger bill had quite a number of co-sponsor. The nice thing about it was it had a lot of votes. We passed it through the United States Senate and made a major move forward in that regard.

I would like to see it further implemented. I have seen much of what Senator Durenberger and I put in that piece of legislation, adopted by others, and we are complimented by it.

Now, I would like to compliment my friend, Senator Leahy, for the leadership that he has shown in working on giving flexibility to the States in addressing these problems of health care, trying to take care of the differences between States, and doing some innovative, creative things.

That is what you did when you introduced your bill, S. 1972, in November of last year, and what you have done in working with the Governors and others in bringing forth the bill we are considering today. We are pleased to have you, Senator. And, if you will forgive me, I am going to go vote and let Senator Baucus preside and try to spare you some time.

STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM VERMONT

Senator LEAHY. Thank you. Thank you very much, Mr. Chairman. I not only appreciate your kind words and the friendships we have shared these 18 years I have been here, but I also appreciate the help that you have given me, the advice you have given me, and the hours of help and aid that your very, very fine staff has given. I appreciate that, Mr. Chairman.

I am glad to have this chance to be here to testify on the States' efforts to provide quality and affordable health care to all our citizens. I think the fact that this hearing is being held today not only gives me hope, but it ought to give a lot of Americans hope.

And we owe a great deal—we Senators and all Americans—to the Governors who are here today. Despite the inability of the Federal Government to move forward on national health care reform, the Governors did not give up. Instead, they went to work. In fact, they are the engine that is moving the country forward today toward a goal that we all share.

In States as different as Vermont or Minnesota or Florida, great changes are taking place. In these and many others, people from all walks of life are urgently calling for health care reform.

The State governments are responding with sweeping reform laws. So, we are here today to find out what these courageous States are doing to provide more affordable health care to their citizens, and to determine what kind of changes we need to make in the Federal laws to make that possible.

Making sure that States do succeed is what the State Care bill Senator Pryor and I introduced is all about. I am honored that so many members of this committee have joined the Leahy-Pryor bill. I want to thank the co-sponsors—of course, Senator Pryor, for his work and effort—Senator Mitchell, Senator Rockefeller, who is here, Senator Riegle, Senator Chafee, Senator Danforth, my good friend, Senator Daschle, Senator Baucus, and you, Mr. Chairman.

You have all joined in this, and I think the fact that we have had this diversity, geographical and otherwise, has helped a great deal. And I might say that the advice that I have received from the members of this committee has been invaluable.

Now, we have to ask, can States succeed at comprehensive health care reform without changes in the Federal law and regulations? GAO says no; the Employment Benefit Research Institute says no. Both have studied the issue. They say the State reform efforts are seriously constrained by Federal roadblocks.

And the Governors we are going to hear from today will add to that research with concrete examples of the obstacles they face. And I am proud that the Governor of my State, Howard Dean, who, incidentally, is the only physician Governor in the country, is here today to talk about the Vermont prescription for reform and the help our State needs to put its universal health care plan into place; a plan that would give hope to all Vermonters.

The purpose of our State Care bill is to remove the Federal roadblocks, not only for States like my own in Vermont, but for others that are committed to overhauling their health care systems.

The major provisions are these, briefly: through a new Federal commission, States with comprehensive reform plans can apply for limited waivers from Medicare, Medicaid, and ERISA.

The Federal commission will approve demonstration projects and oversee implementation, but they will also have the authority to revoke waivers, if need be.

And to be eligible for the waivers, the States have to submit a plan to the Federal commission that is comprehensive. It has got to meet strong access, cost containment, and quality assurance criteria. Our bill authorizes up to 10 State demonstration projects.

Over the past few months we have worked closely with many groups. Let me just name some of those so you understand the diversity and the effort that went into this.

Families USA, the Children's Defense Fund, the National Governors' Association. These, in particular, worked with us to strengthen the protections for Medicaid beneficiaries contained in the State Care bill.

We have clarified language in the bill requiring States to provide mandatory Medicaid services to Medicaid beneficiaries. We have strengthened provisions that assure the high quality and availability of care for Medicaid beneficiaries. So, I want to thank these organizations for their help and their willingness to continue to work on these provisions with us.

But we have also worked hard to carefully construct the most controversial and the most important provision in this bill, and that is the changes to ERISA.

Our bill enables States that are approved under this demonstration program to broaden their current funding base to support access initiatives, but only if the assessments are broad based.

States cannot single out ERISA plans. And I understand, this is the most controversial part. We are not singling out ERISA plans. Everything has to be broad-based.

We also allow States to establish a standard benefit package for employers in the State, with one important exception: employers with self-funded health benefit plans would be exempt from this provision, as long as their benefit package meets a minimum value.

We have included these, and other provisions, in the bill to recognize the legitimate concerns of both business and labor. What we want to do is to help States expand access to care; we are not trying to diminish it.

I do not know a State in this country that has adequate access to care. I do not know a single Governor in this country that does not want to expand access to care. And the ERISA provisions are absolutely essential to the success of State reforms.

There are those who will oppose this legislation on the grounds it will slow progress toward national health care. I disagree. I am a strong supporter of Majority Leader Mitchell's efforts to develop and pass comprehensive health care reform legislation as soon as possible.

But I also agree with the Majority Leader, if we allow States to go forward, it will help us. And I would go one step further. I am willing to bet that States across this country, if they are given the tools to work with, will prove to be the engine to drive through what will eventually be health care for all Americans.

Now, we are not going to stop States from going forward with their health care reforms; they are already doing it. But, instead of preventing them from doing it the best possible way, let us give them the tools.

Because it has happened before in this country, when the States show the initiative on matters that we need, from child labor laws to Social Security, eventually their innovation and their concern at the most grassroots of level pushes the Congress and the President to go forward with what we all need: adequate health care for every single American. And this is the best step forward. Thank you very much, Mr. Chairman.

Senator BAUCUS. Thank you very much, Senator. I see we have about 3 minutes left in this vote. The committee will be in recess until the Chairman returns.

Senator LEAHY. Thank you.

[The prepared statement of Senator Leahy appears in the appendix.]

Senator BAUCUS. Thank you.

[Whereupon, the hearing was recessed at 10:54 a.m.]

AFTER RECESS

The CHAIRMAN. This hearing will come to order. If you would please cease conversation and take seats. Senator Akaka, if you would come forward. We are delighted to have you as a witness.

Senator DURENBERGER. Mr. Chairman, could I ask that my colleague Paul Wellstone's statement be included in the record?

The CHAIRMAN. Yes, of course. Without objection, that will be done.

[The prepared statement of Senator Wellstone appears in the appendix.]

The CHAIRMAN. Senator Akaka.

STATEMENT OF HON. DANIEL K. AKAKA, A U.S. SENATOR FROM HAWAII

Senator AKAKA. Thank you very much, Mr. Chairman. I heartily commend you and the committee for holding this hearing on State health care reform initiatives.

As Congress crafts legislation to extend health care coverage to the over 35 million Americans currently without health care and to improve coverage for the additional 60 million with inadequate insurance, the experience of States is most instructive.

Some States are primed to forge ahead with health care reform plans. I am pleased to say that Hawaii is one such health pioneer which has taken a giant leap forward in the field of health care.

Hawaii has had a longstanding commitment to make health care available to all of its citizens, and we have reached near universal coverage. Because of our commitment to health care, Hawaii ranks among the healthiest States, based on indicators such as low infant mortality, low hospital utilization, and low chronic disease rates.

The cornerstone of the health care system in Hawaii is the Hawaii Prepaid Health Care Act of 1974. Nearly two decades ago, at a time when the Federal Government was only beginning to wake up to the problems of our health care system, the State of Hawaii was boldly moving forward by requiring that employers provide certain basic health care benefits for their employees.

The Health Statute is the first and only such mandate in effect. Over the years, the State has continued to refine and improve this system. Regrettably, the Federal Government has often been the greatest obstacle to allowing Hawaii to expand and improve its system of universal health coverage.

Under the ERISA or Employment Retirement Income Security Act, States like Hawaii are precluded from imposing minimum health care requirements on employers without a specific exemption from the act.

Legislation which I introduced to provide Hawaii such an exemption was enacted by Congress in 1983. Unfortunately, Congress only permitted the State to require the specific health benefits set forth in its 1974 statute.

Consequently, this landmark law has been frozen in time. In order for the Hawaii Prepaid Health Care Act to retain its limited exemption from ERISA, no substantive changes can be made in the act. Eighteen years have passed since this legislation became law, and there is an urgent need to bring it up to date.

Mr. Chairman, Hawaii is not immune to problems of rapidly increasing health care costs and inequitable distribution of care. Hawaii faced a first-time $64 million shortfall in State Medicaid expenditures last year, which it met with State revenues. Estimates point to a 20 percent shortfall for the current year.

Despite having among the lowest health insurance premiums in the Nation, Hawaii businesses are struggling to pay for their em-

ployees' coverage. And, as is the case across the country, our residents have trouble getting care in some of our rural communities.

I have introduced a bill, S. 590, which would exclude the Hawaii health care statute from ERISA. Such an exemption would give Hawaii greater flexibility to improve both the quality and scope of health care coverage for its working men and women. It would also allow the State to eliminate inconsistencies in its innovative approach to health care.

Mr. Chairman, at this point I would like to submit for the record written testimony by John C. Lewin, the director of the Hawaii State Department of Health.

Dr. Lewin highlights the Federal obstacles to State health care reform. He also comments on S. 3180, the State Care Act of 1992, of which I am a co-sponsor, developed by our colleague from Vermont, Senator Leahy, and a member of this committee, Senator Pryor.

The CHAIRMAN. Without objection, that will be accepted.

[The prepared statement of Dr. Lewin appears in the appendix.]

Senator AKAKA. While we fashion and debate comprehensive strategies to close the Nation's health care gap, we must not overlook more modest initiatives, such as S. 590 and S. 3180, which would allow States like Hawaii to expand and improve innovative health care programs that have a proven record of success.

As we move toward national health care reform, I have an apprehension, Mr. Chairman. Hawaii has a system in place which came into being through the cooperation and vision of providers, consumers, insurers, businesses, labor organizations, government officials, and policy makers.

I would not want to see this functioning system, one that has resulted in 98 percent coverage, be abruptly supplanted by another system which would leave Hawaii's people with less health care than they now enjoy today.

Mr. Chairman, Hawaii's experience has much to offer to this discussion of how to reform health care. I ask you to approve legislation to allow Hawaii to continue to be a pioneer in health care innovation.

Mr. Chairman, this is a part of my statement, and I ask that my full statement be included in the record.

The CHAIRMAN. Senator, it will be included in the record. Hawaii has certainly been a leader in innovation and creativity and seeing virtually universal coverage. We are very appreciative of your testimony. It will be helpful to us.

[The prepared statement of Senator Akaka appears in the appendix.]

Senator AKAKA. Thank you very much, Mr. Chairman.

The CHAIRMAN. We have quite a set of panelists here that have yet to be addressed. I recognize Senator Grassley.

Senator Grassley. Yes. I would like to ask you—and this is directly related to just your program, so I think you will be able to deal with it—when the play plan went into effect in your State—and let me back up and say I ask this question because a lot of small businesses in Iowa are concerned about pay-or-play. They think it is going to be very detrimental and ruin small business.

So, the experience in your State on a play plan, where my understanding is they have to offer the insurance, what has been the impact upon small business failure, if you could give me some rough idea?

Senator AKAKA. Yes. The businesses in Hawaii are under strain in our program, but they are able to provide the assistance that is required under the law. As you know, we have in Hawaii the SHIP program, the State Health Insurance Program, which covers about 5 percent of the population of Hawaii.

About 95 percent of the population is covered by what business provides, together with what the Federal Government provides in terms of Veteran's benefits, Medicare, Medicaid, and other Federal programs.

But what most States and what Hawaii lacked before we went into this program was coverage for the last 5 percent. This was accomplished by the State Government under the SHIP program. I feel that the program that is now in place in Hawaii is affordable by the business sector as well.

Senator GRASSLEY. Is there any sort of a subsidy for small businesses that maybe could not provide this plan and would otherwise go out of business if they could prove that?

Senator AKAKA. Yes. Thus far, our small businesses have been able to hold the line. But we have, also, a premium supplementation fund that can help businesses in case they really do need that help.

Senator GRASSLEY. Then my last question is, simply, for instance, the Farm Bureau did a study that national plans—and this would be based upon other countries' national plans—said rural areas generally do not do well under national plans, delivery of services, quality of services, et cetera. Has there been any problems in your State for outlying areas for access to the State plan and the delivery of services with it?

Senator AKAKA. Thus far we have not had that problem. So-called rural areas are covered by sugar plantations which are under this program so that our rural areas have not suffered from this type of program.

Senator GRASSLEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Are there other questions of Senator Akaka?

Senator PACKWOOD. I have one question, if I could.

The CHAIRMAN. Yes. Sure.

Senator PACKWOOD. On the State health plan, as I understand it, your plan is a play only. The employer cannot opt out and dump his employees on the SHIP plan. Those are the people that are statutorily left out.

Senator AKAKA. That is correct. The SHIP plan covers the underemployed, the homeless, and those that would not be covered ordinarily under other health programs.

Senator PACKWOOD. Thank you.

Senator CHAFEE. Mr. Chairman, one question if I might.

The CHAIRMAN. Yes.

Senator CHAFEE. Each of the Governors, I presume, is going to testify that they support the Leahy-Pryor legislation, which I might say I am a co-sponsor of likewise, and so are you.

But my question is, why should it be restricted to 10 States? I think if we take Vermont, Hawaii, Florida, the State of South Dakota and Colorado, that is five States right there. Each of them want it. Why limit it to 10 States?

Senator AKAKA. Well, one of the approaches that we take when anything is new is to see how it works out in a few States. I would say that this describes the current situation, that a few States go into the program and see how it works.

Our particular program in Hawaii has been under way for nearly two decades, so we have that history. But, for many other States, it might be better to try several variations and if they work well, then expand it to the rest of the country.

Senator CHAFEE. Thank you.

The CHAIRMAN. Thank you. Are there other questions?

[No response.]

The CHAIRMAN. Senator, we are most appreciative of your contribution.

Senator AKAKA. Thank you very much.

The CHAIRMAN. Thank you. We are pleased to have the Majority Leader here. I would like to call on him now for any comments he would like to make.

OPENING STATEMENT OF HON. GEORGE J. MITCHELL, A U.S. SENATOR FROM MAINE

Senator MITCHELL. Mr. Chairman, thank you very much for your courtesy, and for holding this hearing on very important legislation. I apologize that I cannot be here for the full hearing, but I ask unanimous consent that I be permitted to submit a series of questions to several of the witnesses in writing.

The CHAIRMAN. Without objection, that will be done.

Senator MITCHELL. And I further ask unanimous consent that the full text of my statement be placed in the record.

The CHAIRMAN. That will be accepted.

[The prepared statement of Senator Mitchell appears in the appendix.]

Senator MITCHELL. I want to commend Senators Leahy and Pryor and Senator Moynihan for their initiatives in introducing the two bills being considered today, both of which, I think, are consistent with and will move us toward the comprehensive national health care reform that we all agree is so desperately needed.

I am particularly pleased that Senator Akaka was able to be with us today. Hawaii has been successful at providing access to health care for most of its citizens for more than 17 years. It is one of the best examples of the benefits we derive from State initiatives and for States acting as laboratories for national health care reform.

I believe that there must be comprehensive health care reform. There is no higher priority for us as a committee, as a Congress, or as a nation, and I will continue to press for that in the near future. The legislation being reviewed today, if enacted, would give some States a head start on national reform. And I think that is a good thing.

It is my hope that we can assure that every citizen of every State has the peace of mind that the citizens of Hawaii enjoy today in

knowing that they are insured against the ever-increasing costs of health care.

So, Mr. Chairman, I commend you for this hearing, the authors of the two bills, and particularly those who have constructed, manage and operate the Hawaii system, which I hope we can all learn from. I thank you, Mr. Chairman, for your courtesy.

The CHAIRMAN. We are pleased to have you. Senator Pryor, I would like for you to make some comments concerning your legislation.

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Thank you. Thank you, Mr. Chairman. I, too, would like to add my thanks, Mr. Chairman, for holding this hearing. I think this hearing is very timely. We appreciate our Governors from various States being here with us today. It has been an honor for me to have worked with Senator Leahy on this matter for several weeks, and also many of my colleagues.

Mr. Chairman and colleagues, I want to ask unanimous consent that a lengthier statement be placed in the record at this point.

The CHAIRMAN. Without objection, that will be done.

[The prepared statement of Senator Pryor appears in the appendix.]

Senator PRYOR. But I would just, if I could, like to applaud the bipartisan nature that we have of support of the bill that is before us. We have the support of the Majority Leader, Senator Mitchell, Senator Rockefeller, Senator Riegle, Senator Chafee, Senator Danforth, Senator Daschle, Senator Baucus and Senator Moynihan. We may have others. We may get our friend, Senator Grassley, before it is over. And I think, with some persuasion, that we will.

I would like to say, also, Mr. Chairman, that I would like to place in the record a letter that I received just this morning from a colleague of Governor Chiles and his colleagues. He is the Governor of our State, Governor Clinton. And Governor Clinton is registering here his strong support for the Leahy-Pryor legislation, and for these attempts to allow greater flexibility in the States.

The CHAIRMAN. Without objection, that will be done.

[The letter appears in the appendix.]

Senator PRYOR. I know full well, Mr. Chairman, that the question of ERISA and the waiver of ERISA regulations is a sticking point, and I know very well that there are people who strongly oppose these waivers. I understand that. We are all mature, we are grown, and we understand why.

But, having said that, I think that this is one of those issues that I believe transcends this opposition. I believe it is time, Mr. Chairman and colleagues, to see if we cannot have a coming together, if we cannot find a common road to walk down. Because this is an approach that I have felt for a long time is going to be one that hopefully is going to prevail.

The States, I think, have lost their patience with those of us in Washington, and probably with some justification. It is hard to achieve a bipartisan support for a major bill like this, but we see very clearly that bipartisan support is emerging for this particular approach.

Finally, Mr. Chairman, I am very sorry that the administration chose not to come. Frankly, I was very surprised, and disappointed at the same time, that they chose not to attend this hearing.

But I hope that ultimately they will be a part and that they will come and offer their constructive criticism, if necessary, and certainly their hoped-for solutions to a more comprehensive health care proposal, and certainly one that allows the States more flexibility.

Mr. Chairman, once again, I ask consent that a longer statement be placed in the record, and also the statement that I have received that I placed in the record of Governor Bill Clinton, of Arkansas.

The CHAIRMAN. Thank you. Thank you very much.

The CHAIRMAN. Senator Moynihan, you have legislation we are considering. Would you care to make a comment?

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK

Senator MOYNIHAN. I would, Mr. Chairman. Very briefly, because we have been here before, and as much as the Senator from Arkansas is surprised that the administration is not here today to talk of his bill, I am surprised the administration is for our bill. That is the first bill they have been for for a long time. I think it is probably Senator Durenberger's influence.

But, very simply, this is a measure, Mr. Chairman, as you know, to make it easier for States to contract with Health Maintenance Organizations for the provision of health care under Medicaid to welfare recipients; a very large problem. To put it in perspective, sir, again, you know, we tend to think of welfare as an isolated phenomenon; it is not.

Almost one-third of American children will be on welfare, AFDC, before they are age 18. In most of our cities, as I think any of our Governors can testify, half to three-quarter of the children will be on welfare at some point in their youth. I mean, we are talking about populations in which the normal experience is to be dependent on welfare.

And, increasingly, access to health care is difficult because private physicians do not want to engage themselves. The regulations make it difficult, and, at times, impossible to contract with health maintenance organizations. Our proposal would make it a State option to be exercised at its own judgment.

The CHAIRMAN. Thank you very much. Well, I apologize to this very distinguished group of Governors that we have with us. We have had the problems of votes in the Senate; some of you understand that.

If you would come forward now. Governor Lawton Chiles, Governor of the State of Florida; Governor Howard Dean, the Governor of the State of Vermont; Governor George Mickelson, the Governor of the State of South Dakota; Governor Roy Romer, the Governor of the State of Colorado.

Each and every one of you has exercised leadership in this very difficult problem, and we are looking for your contribution this morning. Governor Chiles, if you would lead off.

STATEMENT OF HON. LAWTON CHILES, GOVERNOR OF THE STATE OF FLORIDA

Governor CHILES. Thank you, Mr. Chairman. And to Senator Packwood and all of the members of the committee, we appreciate very much the opportunity for us to speak to you today about the Nation's pressing need for health care reform. Mr. Chairman, I have a full statement I would like to be entered into the record.

The CHAIRMAN. That will be done.

[The prepared statement of Governor Chiles appears in the appendix.]

Governor CHILES. I will try to shorten that. We have made some progress in Florida in attempting to work out a health care solution. Certainly, we would prefer a national health care bill, but the longer we delay, the more difficult that is going to become.

So, in Florida today, with 2.5 million people that are uninsured, we have decided that we cannot just tell them that they have to wait till their is a national health care bill. We have got to try to do something now. Certainly, we know the problem is complex. We know that we are extending a lot of people's lives by our extraordinary but expensive technology.

We also know so much in the States, if we continue down that path, there is no way that we can possibly afford it, so we will all reach a point of having to ration care, and that is something that we do not want to do.

We see that each of the major national proposals has some promising elements, but we still seem to fall short of consensus as to how that can be done so a workable compromise can be fashioned to allow us to start making some progress and start using the States as a laboratory.

I certainly compliment my colleagues from Hawaii, Minnesota, South Dakota, Vermont, Colorado, and other States, for providing leadership in this area. Hawaii, we all point to, as the State that has achieved nearly universal coverage.

At the same time, the good things are, their costs are down, and, yet, the indicators of health look very good. Their infant mortality rate is a heck of a lot better than the State of Florida's, an awful lot better than the national average. So, we envy Hawaii, and we want to try to get into that position. We feel the fact that they were grandfathered under ERISA was one of the major factors that allowed them to go forward with their plans.

I personally want to thank Governor Romer for his fine work on health care reform for the National Governors' Association. He has been taking a strong leadership role in that capacity.

In Florida, we passed in March a Florida Health Care Reform. Our goal is to ensure all Floridians that they will have coverage by December 31, 1994. So, we have set that standard out there that we have to meet. We foresee a system that every Floridian will have a family doctor who will serve as a gatekeeper to a managed care system. We know that we have got to go to managed care as opposed to fee-for-service.

It should be clear that in order to do that, we have to have some help from the Federal Government. Ultimately, we know we have to have a national health plan. But, to allow us to make progress

towards that goal, we have got to be able to do a number of things which waivers would help us do.

We are a great believer in the free market and the use of incentives over mandates. But if we are to provide those incentives, we need your help and additional flexibility. We are designing a Medicaid buy-in program for people with incomes up to 250 percent of the poverty level. To complement our buy-in program, Congress should permit us to de-link Medicaid eligibility from public welfare programs like AFDC and SSI.

We need Congress to allow us to implement several other administrative efficiencies that will enhance our ability to serve Floridians better and save Federal and State dollars. We know that there are many groups that are concerned about changes in the current ERISA laws.

The employers and labor want to keep the pressure on Congress to introduce and enact a national system. They want to avoid having to negotiate different insurance benefits in every State and avoid State premium taxes, and be able to trade off benefits for wages.

Still, employers and labor are at great risk under the current system. Right now, most large employers provide comprehensive health care, so they are paying for that. But they are also paying tremendous rates because of the cost shifting for the employees of businesses that do not have insurance.

Companies that provide health benefits are at a competitive disadvantage to those that choose not to offer them. This bites their bottom line, and certainly erodes their profits. So, business and labor have a major stake in seeing that everyone pays a fair share for medical benefits.

Although ERISA exemptions would subject employers to State regulations like other commercial insurers, the benefits are often overlooked. Ultimately, businesses are going to prosper when cost and risk are spread against the entire population.

State reforms permitted by an ERISA exemption would lead to improved coverage, healthier, happier and more productive workers, lower Workman's Compensation rates, improved competitiveness, and greater cost control. I would like to submit a copy of Florida's flexibility proposal and a summary of the Health Care Reform Act of 1992 for the record.

The CHAIRMAN. Without objection, that will be done.

[The proposal and summary are retained in the committee files.]

The CHAIRMAN. Thank you, Governor Chiles. Governor Romer, you have exercised a great deal of leadership on this issue, and we are looking forward to hearing from you.

STATEMENT OF HON. ROY ROMER, GOVERNOR OF THE STATE OF COLORADO

Governor ROMER. Thank you very much, Senator. Today, the issue is not just the subject of health care, it is the issue of the appropriate relationship between two levels of government. We, as Governors, are elected, like you in this Congress. And we simply are not able to function on matters very critical to our States because of Federal law. So, one of the very simple messages that we are asking you this morning is, let us do our job, let us govern.

Now, I would like to put this into context. I carry around in my briefcase these days the GAO Budget Policy of June 1992. And the reason for that is, Colorado has a healthy economy, but we are heading to disaster, along with the Nation. If you take any trend on no action scenario, you will find that, by the year 2020, we have 20-plus percent of our Gross National Product being eaten up by the Federal debt.

If you simply look at the next page, you will see that our ability to save as a Nation is being diminished by our interest costs in the Federal Government. If you look at the net international investment position, it has dropped from 400 million plus to 400 million negative in 10 years.

And why does a Governor come to you and quote those statistics? We have an economic disaster in the making, and health care costs are the main fuel to it. Now, we States have got to be your partners in this solution. All we are asking for this morning is, give us the opportunity to do our end of the partnership.

Now, I want to aim my remarks not just to you, but to the people who are going to testify following me from industry and from labor. I find it very short-sighted that they will oppose the very limited exemptions that we are going to ask for in ERISA. Very short-sighted.

Because their ability to have an industry or a labor force that is competitive in the world is absolutely dependent upon our ability to reduce health care costs. And they are going to follow us to this table and they are going to say, no, do not go.

Let me tell you, we have got a timing problem here. In Colorado, we want to approach this problem. We cannot do it because Federal law has prohibited us from taking our tools and doing our work at home.

Now, we can do this under ERISA with limited restrictions. We can do it in a very carefully crafted limited way—and they are in this bill—and I want to say to industry, you can have your common benefit package. We have made it so that you can have it. But we are simply so short-sighted in opposing solutions that we have got to get over that shortsightedness.

Now, let me take one other dimension. I believe that we need a national solution. This is certainly not the total answer this morning, but it is a step that we need to take. It is a step that will help in two ways. One, you have got a gridlock in this town. You have simply got a gridlock. You cannot move on this issue. Now, that is a fact that we recognize.

We are trying to help you break that gridlock. Give us the opportunity to go out and try some things, and maybe we can develop, one, some patterns, and, two, some political will that is necessary to do this job. That is one gain that will come from passing this bill.

But the second gain is this: we also have got to be a part of the solution. Whatever national solution we come up with, the States have got to participate. And we cannot participate with the present limitations under ERISA.

So, for those of you in the room who are concerned about it, no, we do not want this mosaic because we feel it will get in the way of a national solution; quite the contrary. If you give us the author-

ity to proceed responsibly with appropriate limitations, we will then be in a position to be a part of the partnership of a national solution. For these reasons, we are here this morning. We say, we need this bill, we need to pass it now. We ought to come back in the first 100 days of the next Presidency and do the rest of the job.

But it is very important that we send a signal to the Nation today that we are going to move on with this. And it is very important that you allow 50 Governors to go do what they were elected to do, and that is to govern and to solve a health care problem. Thank you. I would like to ask Governor Mickelson to speak on some other details of this.

The CHAIRMAN. We would be glad to have you. Go ahead, Governor.

STATEMENT OF HON. GEORGE S. MICKELSON, GOVERNOR OF THE STATE OF SOUTH DAKOTA

Governor MICKELSON. Mr. Chairman and members of the committee, as has been addressed from the microphone before me, there are three major points that we, on behalf of the National Governors' Association, want to make. One, of course, is a need for new waiver authority. And I know that that gets controversial when we talk about ERISA, and that has been addressed by others.

But I want to spend my time very briefly talking about the need for two other things, and that is expanded waiver authority for Medicaid and Medicare programs and the need for a simplified waiver process.

I think the simplified waiver process may be a common thread that is in all 60, or whatever number, pieces of legislation that are currently pending before Congress, on this issue.

This is not a new issue for the National Governors' Association. It is reaching a crisis proportion, as Governor Romer has very eloquently indicated a minute ago. Three years ago, Governor Gardner, of the State of Washington, who was chairman of the National Governors' Association, highlighted health care and getting the States involved with Congress and the administration on a solution to our National health care problem. It was the hallmark of his administration. Governor Ashcroft, of Missouri, continued it. Now, Governor Romer has very wisely indicated that this is maybe one of the top priorities of his tenure as chairman of the National Governors' Association.

Well, in addition to the new waiver authority that has been discussed here, the States need expanded Medicare and Medicaid waivers as a part of a comprehensive reform. And the primary interest of the Governors in the comprehensive health reform, just like everybody on this committee, is to make quality affordable health care available to all of our citizens.

And, to do so, the States, as has also been indicated, need the flexibility to modify the existing public health programs and to test strategies that will result in a seamless health care system, meeting the needs of all of the States' citizens.

Now, flexibility—I know that a lot of times there will be criticism of flexibility, because there are some that would question the motives of the Governors or the individual States. It does not mean altering the public policy goals of either Medicare or Medicaid.

Each program must continue that critical function that was put in place several years ago, to provide basic health care to the Nation's elderly, and Medicaid to provide the vital safety net for some of the Nation's poorest, and the most vulnerable populations.

Now, we remain, as Governors—unified, Republicans and Democrats—committed to these public policy goals. Medicare and Medicaid waiver authority was envisioned as a mechanism to improve the effectiveness and cost efficiency of care within the framework of the two programs, not as a process by which these public programs could be incorporated into comprehensive State reform.

We ask that waiver authority be refined to accommodate this change in focus. Expanded waiver authority is needed in the Medicare program. We also talk about cost containment. Sometimes it is hard to imagine that they might be compatible. But, nonetheless, I think our primary goals are the same.

But to achieve the cost containment goals in the Leahy-Pryor legislation, some States want to develop all-payer systems. Currently, the all-payer authority in Medicare is limited in two ways in the Leahy-Pryor bill. First of all, as was pointed out by Senator Chafee, it was written for a limited number of States, just 10 States.

It is limited only to hospital systems, also, and perhaps should be expanded so that it covers other kinds of medical costs. The Leahy-Pryor legislation has broadened the statutory authority so that other States may develop hospital all-payer systems. States would like the bill broadened further so that all-payer systems may be developed.

In addition to expanded Medicare waiver authority, States need more user-friendly Medicaid waivers. The current Medicaid waiver authority is limited, and discourages innovative, cost-effective State reforms.

Depending on the type of waiver, States must conform to burdensome annual accountability, and even more burdensome renewal processes every 2 or 3 years. In addition, States must demonstrate annual cost neutrality.

Now, the Leahy-Pryor legislation eliminates the need for the complex renewal procedure and it allows States to demonstrate cost neutrality over 5 years, which is a practical solution to that problem. The States support the broadened Medicare waiver authority.

Now, as has been pointed out, the States need new and expanded waiver authority to move forward on comprehensive reform. Additionally, the waiver process needs to be simplified, both for Leahy-Pryor demonstration States, and for States implementing reform strategies that are less than comprehensive.

A simplified waiver process would benefit States by providing some certainty that their waivers would be reviewed and approved in a timely manner, and that the duration of waiver approval would be lengthened so that it would not be necessary to reapply as frequently for ongoing waivers.

The Governors maintain that the waiver process must have three fundamental characteristics. Number one, a single entity; again, as I indicated, I think is common thread in all the legislation. Number two, a timely approval process. Number three, the conditional approval of State initiatives as they develop.

In summary, States need new and expanded waiver authority to broaden access to health care and produce some real cost control. The Leahy-Pryor legislation gives that authority up to 10 States to demonstrate some comprehensive reforms.

Now, as has also been discussed, this committee has before it legislation introduced by Senator Moynihan and Senator Durenberger regarding Medicaid managed care that would help States who are interested in establishing managed care systems. The bill would take managed care out from under the waiver process, make significant improvements over the current approach, and is a good move forward.

Finally, before Governor Dean concludes our testimony with a discussion of specific coverage, cost control and neutrality provisions of the Leahy-Pryor bill, I want to share just a personal note.

As we approach national reform, States can experiment with a variety of comprehensive approaches to reforming the health care system. Ultimately, however, we, as a Nation—as Governor Romer said better than I can—must adopt a long-term outlook to health care.

I hope we base our comprehensive reform on free market rather than on government regulation and control, very frankly. But, in our haste to solve our problem of access and cost, it is important that we do not overlook a number of States, including South Dakota.

We are not instituting a comprehensive approach in our State. Instead, I have chosen to take a systematic approach. We have a balanced budget. In fact, we are building a little surplus for the eventuality that we will have to assume more of the responsibility financially in our State.

But we want to build an approach that will provide sufficient coverage and quality care to all of our citizens and at a cost that they can afford by removing inequities and improving the efficiencies of our existing health care system.

I firmly believe that whatever legislation ultimately passes Congress, and whenever it happens, that it will be successful if it is allowed to be implemented with States as a player, regardless of who those Governors might be at that time. We need you to give us the flexibility, you need us to implement and make it successful. Thank you.

The CHAIRMAN. Thank you. Governor Dean, we are pleased to have you.

STATEMENT OF HON. HOWARD DEAN, GOVERNOR OF THE STATE OF VERMONT

Governor DEAN. Thank you. First of all, I want to thank the chairman and also the members of this body who have been, on a bipartisan basis, extremely collegial and cooperative in forming what we think is a very helpful, workable approach towards national health care.

I want to thank, of course, Pat Leahy, my own home State Senator, Senator Pryor, and also Senator Jim Jeffords, of Vermont, who also agreed to become one of the many co-sponsors of this bill.

Let me, first, just say that I think it is extremely important for the Congress to both permit and encourage States to go ahead with

their own efforts. I think that Congress should and will pass a comprehensive health care reform bill eventually.

But, in the meantime, I think that the States have a wonderful opportunity to move ahead, and that both the Federal Government and the State Governments can work in partnership, once the States have moved ahead, and we are prepared to do so, as Governor Mickelson, Governor Romer, and Governor Chiles have indicated.

I think our action here will lead to a partnership, and it is a necessary partnership. But I think—and I feel very strongly, as many of the Governors do—that the States must administer the national health insurance program; that the Medicaid program, which the States administer and for which we both bear responsibility for setting standards for and for financing, is a better model than, for example, Medicare, which has not proven to be—at least from a provider's point of view—a particularly successful model, and, frankly, from a patient's point of view, as well.

Let me finally add, before I talk about some of our concerns about this bill, that the Governors, Republicans and Democrats, have no intention of using this bill to circumvent Federal standards for care delivery for either Medicare or Medicaid patients.

We think this bill is very, very important in establishing universal health care. We have no intention of using this bill to circumvent Federal health standards for Medicare and Medicaid recipients.

As you know, we had the National Governors' Association annual meeting in August and had an opportunity to discuss this bill. We wholeheartedly endorse the concept of this bill. There are some reservations, however, which I will just go into very briefly.

The first, is the bill's access requirements, that the insured population must increase to 95 percent, or at least by 10 percentage points during the five-year projects. We are absolutely committed to doing that.

But it is important, I think, to recognize that particular States which have already achieved a high level of insured status may have difficulty meeting the access requirements, despite the fact that their advances are very meaningful. So, we would ask you to maintain flexibility in those particular standards.

Secondly, as Senator Chafee brought up, there is concern among the Governors about this 10-State limitation. That has been suggested, both in this body, and at the level of the National Governors' Association.

Thirdly, we have some concerns over the cost containment requirements. The requirements in the bill are to start off with cost increases of 3.7 above inflation and gradually move that down to zero over a 5-year period. Again, the differences between the States are critical.

In Vermont, we happen to have a very strong history of cost control. In fact, this year our hospital budgets are going to rise no more than 7.9 percent, which is already within the parameters that Leahy-Pryor sets. That may not be true in other States; we do not believe it is true in other States. Governors, in general, are concerned that there be some flexibility there.

And the final point that I think we have a great deal of concern over is the budget neutrality requirements. Again, we wholeheartedly support this bill. We want to go forward in partnership with the Federal Government, although, of course, we do want to administer these programs for the Federal Government.

But we are somewhat concerned that the cost neutrality provisions may serve as a disincentive to States to test initiatives that might be perceived as having a high financial risk, but could potentially reap significant financial savings or benefits. We would prefer a strategy which allows the States and the Federal Government to share risks and benefits of initiatives.

In Vermont, this past year, we passed a bill which contained the following items. In small group insurance reform and individual insurance reform, experience rating in health insurance will be outlawed in the State of Vermont as of July of next year, in both small group and individual markets.

Malpractice reform: All malpractice charges must be heard by an arbitration panel, and the verdict will be admissible in court, if either the losing party or the winning party prefers to take it to court.

All children under the age of 18 in Vermont, living in families at 225 percent of poverty or below—that is roughly an income of $30,000 or below—will be insured, and are insured under a State program, and we have set up a health care authority and a buying-purchasing pool. By 1994, we expect to offer health insurance to everyone in the State.

We need this bill to be able to do that more easily. And it is the consensus of all of the Governors, both Republican and Democrat, that we very firmly want to support not only the partnership that we find necessary with the Federal Government and desirable, but also that we firmly want to support and hope this committee will take favorable action on a bill like this which would allow us the flexibility to move forward on our own while the national health care reform bill is being put together at the Federal level. Thank you very much.

The CHAIRMAN. Dr. Dean, that is a laudable goal. I wish you well in it. I understand that I inadvertently terminated the presentation of my good friend, Governor Chiles, who was my desk-mate for so many years.

Governor CHILES. Mr. Chairman, I apologize. I should have learned not to pause while you are in the Chair. [Laughter.]

I knew that, but I do not know why I needed to be reminded.

The CHAIRMAN. Well, I tell you, we take advantage of a fellow catching his breath.

Governor CHILES. Yes.

The CHAIRMAN. But the problem we normally find now in the Senate, too many of them catch their breath in the middle of a sentence and it has gotten very difficult. [Laughter.]

Go ahead.

Governor CHILES. Mr. Chairman, I had virtually concluded. I just wanted to say that I am delighted to see the Majority Leader here today, and to have his statement. I think it has become clearer now that we were not going to pass a national bill this year and that

we should try to make some progress. That is, I think, what we are seeing.

The imperative is so strong for us. Every growth dollar that we achieved in Florida this year off of our tax base was eaten up by the cost of Medicaid. And, yet, I have 100,000 new students that entered my schools this year, and we have all of the additional costs that go on for all of the other efforts.

So, the States are put in the position, because we have to balance our budget, of having to raise taxes to take care of our basic needs because our normal tax base is eaten up by this growth picture. And, as these graphs show you, the way it goes, it does more than that, it eats up more than your growth dollar.

So, we cannot sit back and wait for the cavalry to arrive, we have just got to have some help now. And we think, as you have heard all of us say, giving us a chance to experiment would give you much better data as we pursue the national system.

And, for goodness sakes, this time it should not be so top down, as we saw in Medicare and Medicaid, where we are up here begging for the waivers, having to scream because it is all locked up. You do have to allow some flexibility, and I think having these different plans out here would do it.

Senator Chafee said, why limit it to 10 States? We, I think, talked about that, because there are about 10 States now that are ready to begin universal coverage, or to say that they are going in that direction. Now, as far as I am concerned, any State that says they want to go into that, I would like to see them get the same kind of waivers.

We thought the number 10 sort of covers that, that you should require some commitment out of the State that they are going towards a goal. And, again, nothing might be better than this time if you could set a goal for the Federal Government when we expect to have. I think having that force out there that we have to drive ourselves to could be helpful.

The CHAIRMAN. Well, we have shared for a long time, as the Federal Government and the State, a partnership on Medicaid, with the Federal Government paying from 50 to 80 percent of the participation. And the chairman of this committee has pushed very hard for the extension of Medicaid, prenatal care, neonatal care, and all of the rest of it. So has Governor Chiles.

Yet, I am trying to understand what you are speaking of in reform, what you are trying to do. Would that mean that Medicaid would be a part of your reform? Would people who are Medicaid eligible be put under some other kind of public assistance? What kind of monitoring would you anticipate the Federal Government would have of its percentage of the contribution and amount of money that is paid out?

As I understand, Governor Chiles, in trying to reach the objectives of the Leahy-Pryor legislation, that you might need additional Federal financial assistance through Medicaid. Is that a part of the fact that, like my own State, you have a very high percentage who are uninsured? Is it because of unemployment? Is it because of a lot of small businesses? Could you address some of that for me?

One of the things you are talking about, and another thing I think about when you talk about 10 States, if we are talking about

a substantial increase in Federal assistance via Medicaid, is we have the onerous task of raising the money to pay for it in this committee. That is pretty difficult these days as we are trying to cut back on this deficit. Those are our concerns. Would you speak to those?

Governor CHILES. Yes, sir. I will try to. First, we want to decouple the Medicaid from the other benefit package. That is exactly what you helped do to give the prenatal care. We said States could opt to give the prenatal care without having to cover everything else.

When you did that, many of our States that were not able to give that care before—Florida being one of them—went into that very quickly. And, in fact, I think some 40 States have opted into that now, giving that prenatal care.

So, what we are saying is, there is no longer a totally valid relationship between the welfare requirements and the health requirements, and we need to split those. Now, that is one statement for the waiver.

The other is, what we are seeing in Florida, if you allowed us under the Medicaid match to go up to as high as 250 percent of poverty, we think that we could cover most of that 2.5 million people that are uninsured in Florida. Those are the people, some working in small businesses, that are not covered.

But we also think, in doing that, if we are going to achieve universal coverage—and that is what we are trying to do—that that is the cheapest, most efficient way that we can do it. We run a very good Medicaid system in our State, and most of the States do, and that is monitored. The Federal Government monitors that system.

But there is no way that I have seen in any of the other numbers of any kind of national bill that you can get the kind of basic coverage which we think is so necessary to be able to hold the costs down.

In other words, everybody has got to have a medical home in order to keep people from going to the emergency room, driving up these huge costs, and causing the insurance premiums and others to go up.

So, we think the cheapest way we could possibly do that is through the Medicaid match. We would be putting up our share, and the Federal Government would be putting up theirs. Remember, we are having to put up our money for your money, so we are going to be very careful with that. But we feel that it would be the best dollar we could spend because we can drive that to managed care, we can control the costs. We then can require all of the doctors to participate in that. Those are the items why we think that would be helpful.

The CHAIRMAN. One of the other points I would like to ask about, and that is under Senator Moynihan's bill, is on managed care. We have a formula now of 75/25, that not more than 75 of the patients can be Medicare and Medicaid; that at least 25 percent have to be from the private sector. The objective of that was to try to put some discipline in the marketplace so that these people would compete on quality and cost.

Now, as I understand this piece of legislation, that kind of ratio is eliminated. And, for that, you have substituted some rules inso-

far as quality care is concerned and something to try to help on solvency of the HMO's. That is interesting to me. But one of the things I also understand about the legislation is that this would take effect before the regulations were published, and that concerns me some.

Governor CHILES. Well, maybe one of my colleagues could speak to that. I think the only thing I would say is, what we hoped to do by that 75/25 has not worked; that is very clear. Because under the fee-for-service, what has happened, that has not proved to be a restraint. So, what we had hoped for did not work.

The CHAIRMAN. Well, I would urge you to consider whether or not we should, before you do away with these rules, have some regulations published to try to protect quality and to try to protect solvency. Yes.

Governor MICKELSON. Senator, I think this maybe addresses your question. I think there are 20 States that already have these kind of programs in operation right now. I do not believe that we need to wait for regulations.

Traditionally, the Insurance Commissioners from around the States have dealt with that. Now, I know that early on in the HMO's, for example, there were some problems, but I think we have learned from that and we are probably at a point where that is less important now than it was before.

The CHAIRMAN. I see my time has expired. Senator Packwood.

Senator PACKWOOD. Let me start with Governor Dean on this. About, oh, a year, year and a half ago, the Director of the Congressional Budget Office, Dr. Reischauer, testified, and said, in his judgment, medical costs in this country—public, private, all of them—would go to 19 to 20 percent of our Gross National Product by 1996, absent any change of law. That is, if we just continued on the path.

That is the earliest date I had seen. I had seen that figure at 2000, but not at 1996. And there is no question, they are going up. Whether he is off a percent or two, or he is off a year or two, I do not think matters much; they are going up.

In your judgment, can we achieve constraints in medical costs on what all of you would call managed care, and I think I understand the term alone? Are we going to have to prioritize, or, to use a tougher word, ration care, and say there is certain care we are just not going to give?

Governor DEAN. Senator, the system under which we now have health care rations care.

Senator PACKWOOD. That is correct.

Governor DEAN. It simply rations care by lack of insurance, or poor insurance. We are talking about a health care crisis. A number of the members have already mentioned the plight of the uninsured.

It is not the plight of the uninsured that is driving us to some kind of national health care reform, it is the fear of middle-class Americans, who have insurance, who are fearful that their insurance will be inadequate to cope with the incredible costs. In my view, Senator, we are not only rationing now, but we will have to continue to ration.

It would be dishonest if we did not discuss that with the American people. We cannot get out there and promise we are going to fix all their health care problems and make them secure again. We have got to talk about what we are going to have, and what we are not going to have. And, frankly, Senator, your State has come probably farther than any others in having that public discussion, and I regret that you did not get your waiver.

Senator PACKWOOD. Yes. We got turned down for political reasons.

Governor DEAN. Well, I think it is unfortunate, frankly. We would not use your system in Vermont, because our system is a different system. But I think what happened in Oregon illustrates what we need to have.

We need to see five or six ways of going about this—peculiarly American ways of going about this—and then the Federal Government will have the opportunity, I think, and should, impose a national solution. We must be flexible and have the States allowed to go forward, and we must be flexible at the time of the imposition of the national solution and have the States administer the program.

Senator PACKWOOD. Yes.

Governor DEAN. We will not be able to control costs, however, without a global budget. I prefer, and I believe it is more workable, to have a global budget at the State level, and not have one national global budget.

Senator PACKWOOD. Let me ask Lawton, because you said, when we bring everybody in, we will universalize this so they are all covered, that this will give you your ability to contain costs. Maybe you can prevent it, they will not be going to the emergency rooms.

Lawton, I would make you this bet: that those who are not now covered are probably, on the average, sicker, but most of them do not go to the emergency room very often. And, when we cover them, it is going to be more expensive in toto, because they are going to be a more expensive group to cover. We should cover them. I have no quarrel with that. But I do not think it is going to make your average costs go down, I think it is going to make your average costs go up when you bring them in.

Governor CHILES. Well, that, by itself, certainly will not solve everything. But I used to think, Bob, that we could not give universal coverage unless we could control costs. Now, I strongly, strongly believe that, unless you provide universal coverage, you will not be able to control costs. So, it is a part. I do not think it is all, and you are exactly right.

But the other thing, I think, when we say managed care, we are talking about trying to keep people healthy rather than pay doctors for how sick they are for all of the procedures they could use, and so shifting the whole incentive to all of the profession, that we give you your reward based on how effective you are at keeping people well, rather than how effective you are at setting up all of the different procedures, and tests, and labs to see how much money you can make.

When you get that, then I think you will have something that, yes, it may grow, but it will grow—let us face it. We thought we could design something that would control the costs. They beat us

at the game we set up. And, unless we can change it, we cannot win.

Senator PACKWOOD. Now, let me ask you. The main single-payer bill that is referred to around this Congress is the Russo bill, although he was defeated in the primary last March and I have not heard as much mentioned about it since then. But, it folded in Medicare, folded in Medicaid, it wiped out all insurance costs. It was a single-payer system, all right.

The Federal Government would collect all of the money, we would pay all the bills, and would, I assume, set all the standards, in terms of whether we paid hospitals in Ft. Lauderdale more than we do in Ft. Worth, I guess. And it would cost the government an additional, roughly, $600 billion.

Now, you would no longer pay insurance, you would no longer have Medicaid, but there would be a SHIP. Now, if you had that system and the Federal Government says, here is what we will cover, A, B, C, D, E, F, G, H, and there will not be any Medicare, there will not be any Medicaid, everybody is folded in, what should be the role of the States in that kind of a program, any?

Should you be allowed to go below the benefit standards we have if you want to and raise some others, or should the States at this stage just be out of it, and the Federal Government has nationalized it?

Governor DEAN. Is that addressed to anybody who wants to field it?

Senator PACKWOOD. Go ahead.

Governor DEAN. My own preference would be, if you were to enact a single payer—and we both know that there are good things and bad things about a single payer—that we, in essence, have a single payer run somewhat like the Medicaid program where the States administer the single payer, and the cost is shared between the Federal Government and the State Government, and the Federal Government outlines minimal standards below which no State shall go. And I think that will be a possible way to approach that. But I would not want to have a single payer run by the Federal Government.

Senator PACKWOOD. Well, let me ask you, then, because you mention——

Governor DEAN. Excuse me for a second, Senator. I think, along with a single payer, we have got to look at the cost controls in a single payer, and that means that we have got to pay doctors differently than we do now—and I am a physician. We cannot continue to pay physicians by the procedure or we will continue to have twice as many procedures done per capita in this country as we do elsewhere.

Senator PACKWOOD. Can I ask him a last question, Mr. Chairman?

The CHAIRMAN. Yes. Sure.

Senator PACKWOOD. You kind of analogized to Medicaid, Federal/State minimum standards, but below which the State could not go. Yet, this was the argument against Oregon's Medicaid waiver. We wanted to shift the priorities.

And we were going to pay for some things the Federal Government did not mandate, and we wanted not to pay for some things

they did mandate. We thought our priority list was a pretty good list. But there would have been some things that were mandated that we would have gone below.

Governor DEAN. That is why we want this bill passed so you could get your waiver, so we could get ours, so Lawton could get his. So, before the Federal Government acts, we will have a lot more information about which is the appropriate way to go in these systems, and which is not. We think that the Federal Government, as well as each other, will learn from each other's successes and failures as we proceed, and we are ready to proceed now.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Surely. Senator Durenberger.

Senator DURENBERGER. Thank you. I appreciate very much the testimony of these Governors, and also the fact that this is not their first trip here. They have been coming back, and coming back, and the message is the same. I do hope that the people outside this room are listening, as well.

I would like to just make it clear why I am not supporting this particular approach, at least as drafted, and why I am doing a different kind of approach. As everyone has pointed out so far, the restrictions to 10 is inappropriate.

We have already 24 States that have risk pools for medically uninsurable, and every one of those 24 States needs access to the self-insured pool in order to make those risk pools work. And I think that that is an argument that says limiting this only to 10 might not be a great idea.

The second—and this gets more important, and I think Governor Dean raised this one—is the specificity with which this bill addresses qualifying to do your premium tax, or to do your provider tax, or whatever it is you want to do.

As I read the Leahy-Pryor bill—and I have complimented them before, and I will compliment them again for taking on a problem that none of the rest of us really understood very well, and are now helping to educate us—there are something like 20 Federal requirements to be implemented by some Federal commission of one kind or another.

I know my State of Minnesota would not qualify right now, so they would want me to oppose this kind of legislation. They would have to wait until the commission got set up, till everybody agreed on whether the target should be 95 percent coverage, or it ought to be so much restraint on whatever it is. They have got a plan.

They need to get going, because some judge in New Jersey gave some pipe fitters union in Minnesota the opportunity to kill our provider tax. So, for me, this particular mandate and solution is not the right one. Whether my own is most appropriate, I am not sure either.

In other words, I am just saying, if you have got a system that will take care of medically uninsurable, that will start working in the direction of bringing the prices down for everybody in the system, including prices for those who are self-insured, you ought to have a right to get to 100 percent of the covered lives in your State, not just this declining number who rely on insurance plans. So, that is my present problem with this approach.

Having said that, I really must ask you to respond to the cost containment issue. We have not found an answer to cost containment here. Implicit in your urging us to let you do the job of 100-percent coverage is cost containment.

And I have got to tell you, if single-payer systems are going to be the way we go, and they are going to run like Medicaid, I ain't having anything to do with them. And I will do everything I can to make sure that people in my State who are currently being paid 26 cents on the dollar by Medicaid do not have to participate in this kind of program.

I do not want to do anything to discourage employers in my State from forming up 500,000 or 600,000 strong and try to change the behaviors of doctors. So, we may call industry and labor shortsighted in their objections to this, but they have got a vision of what has been going on.

And I think one of their concerns is, what are we going to do in each of these 50 States to constrain these costs, and will it or will it not be beneficial to the enterprise that they are trying to put together? I heard, Lawton, the other day, what is going on in Orlando and Tampa, these coalitions of employers.

Governor CHILES. Right. Yes.

Senator DURENBERGER. And I do not know how many of those folks would be excited about getting rid of the ERISA preemption. But I kind of get a sense that they are beginning to change the behavior of some of the highest-priced doctors and hospitals in American in your State.

Governor CHILES. I do not want to do anything to limit their ability. And I do not think that what we are talking about in Florida does. We certainly do not, at this stage, say we are going to a single pay, or play-or-pay, we are going to try to do it on a voluntary basis, letting us say, oh, kinds of things like, there have to be community rating, we do not allow insurance companies to cherry-pick, to come in and pick off cream, and do things like that. So, we are going to try and do all of those.

We want to see the Medicaid buy-in. And the reason for the Medicaid buy-in is very much part of the cost containment on that. Part of the cost containment is that we are having to put up our share of that money, so we do not want to do that unless we think it works. We may be wrong, but if you do not let some States experiment with this, whatever you do in the national solution, it will come out as to one thing, and it may be a national disaster, because it may not work. And if it is going to be a failure, let Florida fail, maybe, or let Vermont fail in what they are trying to do. But some of us are going to hit at the same time, and that is going to show some of the things that do work.

So, we are not saying that we want to go away from that private-sector force, but the only thing we can say at this time, David, is it has not worked yet. And I think it still will not cover the problems we are having in our 2.5 million uninsured people who now go to the emergency room, wait till their so sick that the costs go up, and give us these greater problems. So, it will not cover that. So, again, we think that allowing States to experiment is just the way that you have got to go.

Governor DEAN. Perhaps I could just make one point. I do not want you or the committee to go away from this discussion thinking that we are advocating a single-payer system.

Senator DURENBERGER. I do not.

Governor DEAN. Nor do I, as a physician, want you to go away from this discussion thinking that I advocate the reimbursement rates that all of us as Governors are paying physicians. But the reason we point to the Medicaid system is because we think it is well-administered because it is administered by the States.

The CHAIRMAN. All right, gentlemen. Senator Daschle.

Senator DASCHLE. Thank you, Mr. Chairman. Governor Romer, it sounds like the critics of this approach, and perhaps other approaches that are similar in nature, have three primary concerns with respect to waivers and greater State flexibility.

The first is higher administrative costs overall. The second, is competition between States based on lower cost for business. That is, as one State recruits businesses, they can claim they will have lower health care costs because they will have more waivers in that State than in others.

And, third, that we will have inequitable access to comprehensive health care. Those three concerns keep arising as I talk to opponents of the legislation, and as I listen to those who have argued against it. How would you respond to those three concerns?

Governor ROMER. First, on higher administrative costs, I think we will have lower administrative costs. Because if we get the right to have some uniform billing and some other procedures, I think we can cut administrative costs. States are innovating in different ways of doing this. Colorado has a plan called Colorado Care, which we feel can substantially reduce administrative costs. So, I believe that our opportunity to innovate will reduce administrative costs. Competition between the States, you know, I had not thought about that one. I think that is a good idea, not a bad idea.

I frankly feel that we have got to solve this problem and anybody who is in the business of trying to be competitive in the world marketplace knows they have got to find a place where they can put their employees wherein they are not only healthy, but they can afford that health care and it is a reasonable cost.

And I think that if we have some competition among various approaches, that is probably healthy. And I think the most effective, delivering the best quality, the lowest priced is going to win out. So, any pain that a particular State may be in because somebody is doing a better job next door is probably necessary pain, and good pain.

Third, on the inequality, you are right, this is a problem. We eventually need a national solution. We need a national solution. But I think we need to proceed down this path so that you can begin to allow us to experiment, as Governor Chiles said.

And we will have to live with the inequality that we may produce, and hopefully that there will be a follow-through on a national basis quickly enough that we can avoid the kind of disjuncture that you have where somebody gives something and somebody else does not.

Senator DASCHLE. Let me ask Governor Mickelson. Just an observation. As we debate national health care reform, it seems to me

that businesses are probably concerned more than anything else with the extraordinary proliferation in the cost of providing health care for their employees.

We talk about a level playing field with international competitors, and they say that we are virtually the only industrialized Nation requiring employers to provide health insurance to their workers. Very few other industrialized countries place that burden on businesses.

Given the administrative hassle and costs, given the burden this is placing on them for competitive purposes, what value, what purpose is there in continuing to require employers to provide health insurance? Is there another way? Would you advocate looking at options other than mandating employers to provide health care as they do today?

Governor MICKELSON. Well, I personally would advocate another plan or an alternative to mandating that employers provide the plan, and I think it becomes our responsibility, Senator Daschle, to provide the framework for that.

For example, under lots of scenarios that are being discussed in Congress today, one of the things we are looking at in South Dakota is a basic health care package and negotiation with insurance companies on what that might constitute, and expanding our coverage base under some sort of a system where there would be a high-risk pool to ensure that the employees would have the coverage. Frankly, the employers that I run into want to provide health care coverage to their employees. I think you are exactly right, their main concern is cost.

But I would look at all sorts of alternatives to mandating it, and I do not think that mandating it would be the appropriate thing. But, we need to help negotiate. For example, in Senator Moynihan's bill, waivers would not be necessary under the negotiation process with HMO's, as I understand it, at least. I think that that is one approach, and I think that is a good approach.

I think that competition is, as has been brought out before, is absolutely essential. We are beginning to see that in our State where there is competition between hospitals and other health care providers that are making consumers smarter than they were before.

I think we need to take a look at restricting future insurance mandates. Those are, at least, very difficult to quantify, but, I think, play a role in it. Then, lastly, impose small group and individual insurance rating restrictions, perhaps. So, I think there are lots of alternatives that are available to us.

The CHAIRMAN. Thank you.

Senator DASCHLE. Well, I thank the Governors. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Grassley, for any comments you might have.

Senator GRASSLEY. I suppose any of you can respond to this, but, because it deals with Senator Chiles' program, I would ask him. I have expressed this concern before this morning about the delivery of services in rural areas, and particularly we have heard from other studies that managed care will not work well in rural areas, and it is partly because we have a fewer number of health care people in those rural areas.

You have stressed that your Florida plan looks towards getting everyone into some kind of a managed care program, and, of course, Florida also has a lot of rural area as well. So, how have you seen this plan working to deliver services in rural Florida?

Governor CHILES. Well, I think that the managed care could be, even with a family doctor, that you are saying to that doctor, we are going to pay you on the basis of patients that you have, keeping still a managed care scale of keeping those patients healthy.

But what we are attempting to do in Florida is to break a little bit of the cycle where you had the sole practitioner and try to have more practitioners sort of gathering together into a clinic or a place in which they can associate with each other and help themselves that way, and then have them cover people in that regard.

Senator GRASSLEY. Now, do you see, though, that you can bring those sort of groups together in rural areas? I know you can in urban America. But it just seemed to me like a terrible problem. In rural Iowa——

Governor CHILES. Well, I cannot tell you that we have totally done it in Florida, but there are some pretty good experiments out there that we looked at, and some of them are in the Midwest, where they have brought clinics together and have very good medicine practiced there.

Senator GRASSLEY. Governor Mickelson.

Governor MICKELSON. Well, Senator, in your State, and certainly, to a greater extent in my State, rural health care has a different kind of definition than it does in rural Maryland or rural Illinois, or lots of other States, for 55 percent of my State is classified by HHS as frontier, not just rural. And the very issue that you talk about is a very real issue, and here is how we are dealing with it.

First of all, there is legislation pending before Congress right now that expands the Federal agencies. When Senator Bentsen talked about the infant mortality on Indian reservations in my State, it is over twice the national average. It is a disgrace, and we need to deal with it. But expanding the Federal health agencies in those rural areas, particularly in Indian reservations and so forth, is really something that I am very concerned about, and I know that most of our States are.

But, dealing with emergency medical services, training nurse practitioners and mid-level practitioners—we have prioritized what we believe are the most important in our State keeping some rural hospitals open.

We are not going to probably keep them all open, but changing the mission and working with communities in those rural areas of putting together a complex just like you are talking about that is unique, perhaps, to rural or frontier kinds of areas, is a very important part of this whole health care agenda. But, to answer your question, it can be done. We are working on it, and it can be successful.

Senator GRASSLEY. Again, Governor Chiles, explain this pool purchasing cooperative that you have for public service employees, how that might work.

Governor CHILES. Well, it is not just public service employees, it is the small businesses we have started. And Senator Bentsen has included that in his legislation. Basically, what we have is allowing

small companies to come together to get the same kind of discount rates that large companies can have under the insurance coverage.

And what we have done in Florida is we have subsidized mainly the administrative costs, so we feel by putting the administrative costs out there to allow someone to bring these businesses to come together, then they are able to get much better rates.

And we feel it has been very cost effective, what we have been able to do, and allowed us to broaden our coverage. Because this is a way of allowing that small business to be able to give a minimum benefit package to its people.

Senator GRASSLEY. Was this based upon something that you were doing for public sector employees, or was there not any tradition in your State on this, any precedent in your State on this?

Governor CHILES. No. Well, for public sector employees, certainly, you have got a discount, because you were bidding off the insurance off of large scales. So, to that extent, yes, that may be helpful.

Senator GRASSLEY. All right. Thank you. Would you anticipate that small businesses would come into a public employee plan under this procedure that you have?

Governor CHILES. Well, we have certainly had a lot of small businesses that have come into our plan. And, as fast as we have been able to give additional money and get the legislature to provide additional money for those administrative costs, we have been able to go into other areas. We started off in Tampa.

We are now in Tampa, and Orlando, and in Jacksonville. This is expanding and the small businesses really are wanting to cover their employees. And where they are getting these benefits, we have had a lot of them sign up.

The CHAIRMAN. Thank you. Senator Moynihan, for any comments you might have.

Senator MOYNIHAN. Well, Mr. Chairman, my comments will be subdued on any occasion in which David Durenberger says that he needs to be educated about a subject. I feel fear to declare my ignorance. I have been on this committee for 16 years, and for 16 years we have had officials come in, saying we want to keep costs down; and yet, costs keep rising.

And you asked about this behavior, and you would say, well, that suggests a system in which the people who say they want to keep the costs down, in fact, do not, or they want other things which preclude costs being kept down. And no one has ever been very reflective about this; they do not try to tell you why they think things happen. And you start looking around for the unexpected case, which is a pattern in research, I guess.

Fleming walked into his lab at the Paddington Hospital, and there were some petri dishes on the window sill, and they had a culture in them that was not supposed to be there. That interested him, and the next thing you know, we have penicillin, because of something that was not supposed to happen.

I found an example, I was just telling the Chairman, which, again, I did not expect. Rochester, NY is a prosperous city, a city of high technology, great universities, hospitals. Their Blue Cross/Blue Shield per capita cost is one-half that of the State of New York itself and about two-thirds that of the Nation.

Now, why does a prosperous city have the lowest costs? You can think of a lot of reasons. I don't know. Something is going wrong. I mean, in the last 10 years the health care costs have gone up 600 percent. There is a reason for that that no one ever tells us. Does anybody ever tell you, can you segment it? Imaging, 12 percent; AFSCME, 22 percent; whatever.

Governor CHILES. Well, I will take a swing at it.

Senator MOYNIHAN. Yes, please.

Governor CHILES. And I want to say that, while you say those costs have gone up the 15 years you have been here, I just want to remind you, Pat, they kept going up after I left. So, it was not all my fault. [Laughter.]

I think there are a number of factors in this. Certainly, the administrative costs, depending on what study you want to look at, is huge; anywhere from 25 percent to a third. So, there is tremendous paper shuffling that goes on, and part of it is the requirement of the Federal Government or of the insurance company, Blue Cross/Blue Shield, whatever it is. But there is an awful lot of shuffling of papers which takes an awful lot of cost.

Senator MOYNIHAN. And there is an interest in that. People who shuffle papers get paid.

Governor CHILES. Absolutely.

Senator MOYNIHAN. And they have votes, so you have an interest.

Governor CHILES. Oh, it is a huge payroll, there is no doubt about it. If you look at Blue Cross/Blue Shield and their employment, it is a huge employer always trying to seek workers coming in, train workers that are handling these claims, and they burn out after a certain period of time, they can only do it so often. And everybody is into that, so that is a huge cost.

But I think, again, when we thought, by the DRG's, that we could control things, when we thought, by some of the clamps on fees, that we could control things, then we went up to the referral situation with the lab tests, the defensive medicine that goes on, the referrals.

In Florida, we are trying to outlaw the physicians owning any interest in any of the labs, because, let me tell you, that expands those costs. So, those are just two or three of the facts.

Governor DEAN. May I just make one point? Just an interesting anecdote, which I am sure you will enjoy. The State of Hawaii, which is the only State that comes close to universal access, began their universal access program in 1974.

At that time, their costs and California's costs were approximately equal per capita. Today, the costs in Hawaii are 60 percent of the costs in California. So, I think that underlines the point that Governor Chiles was making, that universal access, in fact, can lead to cost containment.

The other point I would make is, as long as you continue to pay—in this current insurance system that we have in this country—doctors to do very expensive things, then we are going to do very expensive things. You have got to change the reimbursement system if you want to change the way the cost curve is going.

Senator MOYNIHAN. Governor Romer has not spoken.

Governor ROMER. I know the red light is on. I will be brief. Senator Moynihan, since I took over the Chair of the National Governors' Association, you know my concern with the Federal deficit. And it is obvious that health care costs are driving it more than any other thing.

When I come to this town, all I hear is people talk about coverage. I do not hear them talking enough about what those real costs are. They are very complex. Let me say, it begins with the U.S. Tax Code and the deductibility we have given firms for health care expenses. It begins there.

It goes to the way in which we have structured the delivery of medicine. It goes to a whole problem we have of, it is not my money, it is the third party pay system. We have a very, very severe responsibility to break into that and to find a way to simply reorganize it radically.

And, sir, what I am concerned about is the time line. You see, we now have a possibility of getting out of this deficit problem because we have the Baby Boom still working. If we delay too long, that retired group will make it impossible for this country to absorb the pain that they are going to have to absorb.

So, sir, what I hope we can do very quickly, in addition to passing this bill, is to come back after this election and put on the table, both of the administration and Congress, in the first 100 days, the painful medicine that we, as a Nation, have got to take in order to cure this problem and begin to go another direction in reducing health care costs and deficit. Because the longer we delay, the more painful the cure.

Senator MOYNIHAN. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Pryor, for any comments you have.

Senator PRYOR. Mr. Chairman, thank you. Mr. Chairman, in the interest of time, I am going to submit two questions to the panel.

[The questions appear in the appendix.]

Senator PRYOR. One of those questions that I am going to submit—you might want to be thinking about it—is, I would like some real, live examples of frustrations that you as Governors face on a daily basis in dealing with the Federal regulations that we set up here. I am concerned that our Federal regulations and restrictions have really caused difficulties and, in fact, may have ultimately caused you to deliver fewer services to the people that you represent.

Second, I would also like to ask each of you in your States to try to give us a ballpark figure about the number of paper shufflers you have to hire because of our Federal requirements. I think this is something that oftentimes we lose sight of.

I think it would be helpful to us to have that information from the four States represented here. And my real, live question, if I might pose this to Governor Dean. Do you think that, if we go forward with the Leahy/Pryor legislation, we going to slow the progress toward national health care reform?

Governor DEAN. Senator, I think you are going to speed it up so fast that the only thing I can think of in comparison is the Social Security system, which 26 States——

Senator PRYOR. Why are we going to speed it up?

Governor DEAN. Because you will have people in Vermont, and Florida, and Oregon, and Colorado, et cetera, with the universal access system. Americans move back and forth across this country at a tremendous rate. What starts in one State is going to be looked at in other States, and there is going to be even more pressure, not less pressure, to enact a comprehensive plan.

And then what is going to happen is, you are going to have a small patchwork of five or six States that have national health insurance, and the multinational companies and the unions are going to say, wait a minute, we cannot have five different plans; Federal Government, you have got to enact your plan. So, I think by permitting us to go forward, you will immeasurably speed up the progress towards a national comprehensive health insurance bill.

Senator PRYOR. I thank you for the answer. Mr. Chairman, right now, in the interest of time, that concludes my questioning.

The CHAIRMAN. Thank you very much. Gentlemen, it has been very productive. It is good to have people who have to face the problems there at home sharing these concerns with us. We are very pleased to have your contribution.

The one thought I would leave you with is the problem, Governor Romer, that you were talking about, the deficits. I share that concern. I have felt very strongly that nothing comes out of this committee that is not paid for. And I look at the possible expansion of Medicaid.

CBO tells us that if we allowed the option for the States to take currently ineligible individuals with incomes below the 150 percent of the poverty line, that we would have to come up with another $97,300,000,000 over 5 years. If we made it mandatory, it would be $187 billion. So, those are some of the problems and concerns from our point of view. Thank you very much for your contribution.

Our next panel: Mr. Gary J. Claxton, who is the senior analyst for the National Association of Insurance Commissioners; Karen Ignagni, who is the director of Employee Benefits for the AFL–CIO; and Robert Stone, the senior corporate counsel for IBM Corp., and chairman, board of directors, The ERISA Industry Committee, on behalf of that committee. We are pleased to have you. Mr. Claxton, if you would proceed, please.

STATEMENT OF GARY J. CLAXTON, SENIOR ANALYST, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, WASHINGTON, DC

Mr. CLAXTON. Thank you, Mr. Chairman, and members of the committee. And thank you for this opportunity to discuss the pressing issue of ERISA waivers for States undertaking comprehensive health care reform. I am Gary Claxton, a senior analyst with the National Association of Insurance Commissioners.

Commissioner Tim Ryles, of Georgia, who was invited to testify here today is unable to appear because of illness. He asked me to convey his sincere support for the important inquiry that you are undertaking today.

ERISA, for all its strengths in the pension area, is proving to be almost an insurmountable barrier to State health care reform efforts. Many States, impatient with progress of health care reform at the Federal level, are committing themselves to far-reaching re-

forms in the area of access, quality, and health care costs. Many of these efforts attempt to build on the private health insurance market that has been successful in the past.

Unfortunately, ERISA acts as a barrier to these State health care reforms because ERISA preempts virtually all State efforts to regulate or otherwise affect self-funded employee health programs.

This cripples State efforts in a number of important areas. First, self-funded health plans now account for over 50 percent of the private market coverage. States simply cannot undertake comprehensive reform when over one-half of privately-insured persons are beyond their reach.

Second, self-funding is primarily a tool for larger employers and health plans, the arrangements that are most stable and easiest to insure. States are left to direct their efforts only to smaller employers and individuals who are much more difficult and costly to insure.

As self-funding becomes increasingly popular with a more stable segment of the private insurance marketplace, States are becoming less and less able to implement innovative reform strategies based upon the principle of broad-based pooling of risk.

Third, ERISA preempts States from regulating virtually any aspect of a self-funded employer's decisions regarding health benefits. This includes employer decisions about such things as whether to provide coverage, and what level of coverage to provide.

Further, while States' designed pay-or-play programs may ultimately pass ERISA scrutiny, the inevitable court challenges will take years to resolve. States cannot realistically design reforms that build upon the current employer-based system if they cannot affect the decisions of employers without an ERISA challenge.

Finally, ERISA preemption has more recently been extended to areas of State action that only indirectly affects self-funding employers. For example, a District Court recently invalidated a State hospital rate setting system because it contained surcharges to cover uncompensated care and other health related costs.

The basis of the court's decision, that ERISA plans cannot be required to cover costs beyond those actually incurred by plan participants, underscores the bifurcation of the health care system brought about by ERISA preemption. When one-half of the market is permitted to say, it is not my problem, it is impossible to have effective and comprehensive health care reform.

For these reasons, States need relief from ERISA preemption in order to pursue comprehensive strategies to improve access and reduce costs. The NAIC commends Senators Pryor and Leahy for taking a leadership role in addressing these problems by introducing S. 3180, the State Care Act of 1992.

We believe the passage of S. 3180 would substantially broaden the horizons of States seeking to implement comprehensive market-based health care reforms. While we have some concerns about the bill's limitation to 10 States, we strongly believe that its adoption would encourage even greater State efforts to address the staggering problems that plague our health care system today. Thank you very much.

The CHAIRMAN. Thank you.

[The prepared statement of Mr. Claxton appears in the appendix.]

The CHAIRMAN. Ms. Ignagni, if you would proceed.

STATEMENT OF KAREN IGNAGNI, DIRECTOR, EMPLOYEE BENEFITS DEPARTMENT, AFL–CIO, WASHINGTON, DC

Ms. IGNAGNI. Thank you, Senator. Good morning. We appreciate the opportunity to convey our views on S. 3180 and want to, also, echo the sentiments that have been expressed already by many of the individuals who have come before us in terms of the effort to deal with access and cost containment, which are the two problems that are dogging us as we try to go forward with our health benefits charges in the labor movement.

The men and women of the AFL–CIO have long believed that the most efficient and effective approach to the health care crisis involves a national solution, as opposed to 50 separate State plans. Moreover, we believe the opportunity for consensus is fast approaching, and that the key goals embodied in this proposed legislation can, in fact, be achieved nationally. I think some of that discussion was reflected in Senator Chafee's comments earlier.

I was disappointed to hear the characterization of our position with respect to this legislation, so I would like to take my time to explain to you the concerns we have about the legislation as introduced.

From labor's perspective, we have seen the issue of health care nearly consume the collective bargaining process. In every industry, employers have moved to cut back on health benefits, or have demanded that union members sacrifice wages and other benefits just to keep the benefits we have negotiated. For more than half of union members who are forced to strike, health care is the number one issue.

As it stands, the free market rewards employers who deny health benefits to their employees. This has created a cross-subsidization in health care that drives costs up even further. We have learned, through several years of painful experience, that, absent government action, there will be no end to this cycle.

In theory, the State Health Care Act would address this urgent need by giving increased flexibility to States so that they could design their own programs while debate proceeds at the national level. In practice, however, we are concerned that the act could well postpone national reform for several years, while the results of State demonstrations are analyzed.

Another concern involves economic pressure on the States that we believe should not be ignored. Many States are currently facing severe fiscal constraints that would limit their ability to initiate comprehensive health care reform.

With actual revenue falling far below projections, many States have had to endure multiple rounds of budget cuts and tax hikes as they struggle to balance their budgets. So, it is doubtful in our mind that States could proceed on their own without additional Federal support to move in the direction of the goals articulated in the bill.

Through our States, trade unionists have been working in a variety of coalitions to advocate policies that are consistent with our

pursuit of national reform, and many of the goals articulated in this piece of legislation.

At the State level, unions have advocated cost containment legislation designed to stem the tide of health care inflation. We also have advocated universal access proposals that depend on broad-based and equitable financing measures.

In consulting with our State bodies, it appears that States that have enacted legislation, as well as those that are evaluating proposals to go forward, are encountering the same problems that Congress has faced, particularly with respect to the issue of whether employers should be required to contribute to the cost of health care coverage, and the difficult task of designing fair and equitable systems.

So, we believe there is cause for skepticism and room for concern as to whether or not the States are in a better position to break the political deadlock that exists on health care.

Let me just comment on some of the particular bills that have been passed thus far. As you know, Florida is a voluntary system until 1994. It is unclear what will happen after that. Minnesota finances uncompensated care by imposing surtaxes on health care services, thereby disproportionately penalizing those that are already providing health care protection.

We look forward to the results of the Vermont study, but, thus far, it is in the study phase of developing legislative alternatives. I would like to turn my attention, now, to the New Jersey situation, which has been much talked about in this session thus far this morning.

In that State, the State Government placed a surcharge amount to 19.4 percent on all hospital bills in order to pay for the provision of uncompensated care for the State's nearly 1 million uninsured.

New Jersey's labor leaders oppose the plan, arguing that the tax forces unions and employers who are paying their fair share to subsidize their competitors, employers who refuse to do their fair share. It was never an issue as to whether or not our unions were willing to pay their fair share equitably and cover the cost of uncompensated care. What they objected to was a disproportionate financing system.

With health care costs skyrocketing all over the country and dramatic increases in the number of uninsured individuals, our members fear that other States will seek ERISA waivers to pursue regressive financing measures without being able to address the larger issues that underlie the health care coverage.

In our view, health care reform is the responsibility of government, employers, and individuals, and we are committed to several principals: that all Americans, 100 percent of the individuals in each State, are entitled, as a right, to a core benefit package; that employers should contribute fairly to the cost of care, and that financing should be done on an equitable and progressive basis.

We are, Mr. Chairman, as usual, prepared to roll up our sleeves and look very carefully at this and other measures. We have no desire to stand in the way of providing additional access to care for the people who do not have it, which includes many of our union members. On the other hand, we want to be very careful in not

supporting a particular direction that may, indeed, make the problem worse. Thank you.

The CHAIRMAN. Thank you.

[The prepared statement of Ms. Ignagni appears in the appendix.]

STATEMENT OF ROBERT S. STONE, SENIOR CORPORATE COUNSEL, IBM CORP., AND CHAIRMAN, BOARD OF DIRECTORS, THE ERISA INDUSTRY COMMITTEE, ARMONK, NY, ON BEHALF OF THE ERISA INDUSTRY COMMITTEE

Mr. STONE. Thank you, Mr. Chairman, and members of the committee. I appear today on behalf of the ERISA Industry Committee, better known as ERIC. I presently serve as ERIC's chairman. We are submitting a full statement for the record today, along with a copy of the ERIC interim statement on health care system reform that we have distributed widely on the Hill. We will make sure that all of the Governors who testified here today receive a copy as well, since I think they will find a great deal of consistency with our view for the long term, rather than the short-term solution to this problem.

[The information appears in the appendix.]

Mr. STONE. My remarks today will primarily focus on urging this committee to reject any attempt to weaken ERISA's preemption of State laws. ERIC's 120 member companies voluntarily provide coverage for approximately 25 million participants and beneficiaries. The subject of these hearings is not new to ERIC. It has been our duty to try to come back with good arguments against attempts to limit ERISA preemption since ERISA was first enacted, and we testified as far back as October, 1977 before the late Senator Javits on these very issues. I was one of the spokespersons at that time and I stated then that ERIC strongly believed that Federal preemption of State benefit laws was essential to the stability and growth of the private pension and welfare benefits plan system. Fifteen years later, ERIC remains steadfast in that belief.

Preemption, as ERISA's legislative history proudly shows, was seen as a crowning jewel in the Employee Retirement Income Security Act of 1974. Employer-sponsored health and welfare benefit plans, especially those of employers such as ERIC members who operate across State lines, including many that operate in all 50 States, have prospered and grown since ERISA was enacted. Preemption, and the national uniformity it fosters and protects, enabled employer plans to successfully provide health and medical coverage that reflects the individual objectives of employers and employees as well as the agreements between them as to what is best for the particular employment environment in which they operate.

With that introduction, I think it is not surprising that we are in opposition to S. 3180, with regard to its ERISA preemption provisions for the reasons that follow. First, S. 3180 would permit States to tax and thereby control employee benefit plans.

Second, it could require employers to convert their uniform, nationwide plans to comply with disparate requirements of at least 10 different States, as Governor Dean predicated in his testimony, and possibly 50 or more jurisdictions.

An example of that disparate compliance would be a company that had a nationwide system for processing employee benefits claims in all 50 States. That company would now have to change that processing system for any and every State that enacted its own unique system for the processing of employee benefit claims.

In addition, S. 3180 would likely increase both employer and employee contributions, and it would disrupt some very carefully negotiated health care provider arrangements.

This crazy quilt of over-regulation represents what State legislatures deem appropriate, not what employers and their employees deem appropriate and affordable within their employment environment.

And ERIC believes, consistent with some of Senator Durenberger's remarks earlier, that the proposals circulating in State legislatures do not require changes in ERISA preemption provisions in order to advance the objectives of increased access and coverage for the citizens of their States who are not covered by plans such as ERIC for example, those States are not barred from financing their plans by way of general revenues.

Let us remember, the mobility of the work force is essential to improving America's competitive edge and employees need to know that their health benefits are consistent and predictable, regardless of being transferred to work locations in different States.

ERIC is fully aware that States face serious problems of finding the resources necessary to provide health care and other services. Let's face it, many employers are facing the same problems. So, where ERIC members see proposals to finance local health care reforms by taxing employer plans that already provide benefits to citizens of those States, we object.

We do not wish to prevent States from expanding health care coverage, nor do we believe ERISA in any way prevents that expansion. We just ask that any such expansion not place a disproportionate burden on the employer community, which is already paying for the costs of providing health care to a large segment of our population.

We look forward to continuing to work with members of this committee and the rest of Congress in finding a nationwide resolution to this very difficult problem. Thank you.

[The prepared statement of Mr. Stone appears in the appendix.]

The CHAIRMAN. Well, I would say those are very definitive statements. None of you fuzzed up your answers, and I appreciate that. I apologize to you, I have another commitment. But Senator Moynihan will continue, and chair the hearing. Thank you.

Senator MOYNIHAN. I always learn a lot more after I have heard from David Durenberger. I wonder if you would like to start the questioning?

Senator DURENBERGER. Well, I am obviously so complimented by my colleague from New York's comments that I should not even ask questions. But I must, particularly of the second and third panelists, because I really have a sympathy with the position that you have taken to the problem of universal coverage and the financial risk that is involved and access to health and medical care. We have to have a Federal solution. We have to have a national solution. We have to have a comprehensive solution.

We are wasting too many dollars in tax subsidies and Medicare supplemental insurance, and a whole variety of things; Medicaid paying for nursing home care for the elderly instead of paying for poor moms and kids, and stuff like that. We definitely need to attack this Nationally. My problem is, sitting on this committee, being a citizen of the State of Minnesota, we are not doing it, and I do not know when we are going to do it.

I objected to the characterization of labor and industry as being shortsighted, because the real shortsighted people are the politicians. They are the candidates for President of the United States who are not giving us any kind of a vision of where we ought to be going so that you could see where ERISA changes might fit in that change.

If you just look at where you are today, 900 benefit mandates, that is the history of what States have done to you. They have raised the costs. I mean, they have not done it to ERIC members, but they have done it to everybody else. That is current history.

Who wants to rely on that kind of history for what is going to happen in the future just because now, all of a sudden, they say it is a new ball game? I do not think it is appropriate to characterize your objections as being shortsighted.

I think, for very valid reasons, both labor and industry, you are, at least, perceived as saying no. I am sure you are saying no. I am not sure whether you could be persuaded to say yes to something, and that is the point, I guess, of my question.

If we knew we were not going to get national change in the short term, and if we knew that States were going to, at least, take care of the medically uninsurable, at least start moving us in the direction of changing experience rating to something else, as States now are positively, one at a time—in Oregon, and Vermont, and Minnesota, even in Florida and places like that—beginning to move in the direction of making these prices for these services more equitable, why discourage them? Because, clearly, Mr. Claxton told us we are discouraging them.

To the extent that people seek protection under ERISA, you are narrowing the base under which some part of this problem can be resolved. So, the question I need to ask—I think maybe Mr. Stone, first, and then Ms. Ignagni, because I admire the leadership both of you have provided over the years as long as I have; well, Ms. Ignagni has not been here as long as I have, but certainly Mr. Stone.

Among the objections that you listed, the first one was, a tax. I have got a bill put together, and I am probably going to introduce it tomorrow because I got some encouragement, including from some of the folks that are on the Pryor-Leahy bill, and those who are not, to do so, all my does is authorize a tax.

It does not get into all those other things you objected to. It does not set up a national commission, a national bureaucracy, 20 different regulatory approaches which will be 40, 60, or 80 before they get all through with this, which insurance commissioners may like, but you and I do not.

My proposal says, if a State like Minnesota decides that it is going to deal with the medically uninsurable, that it is going to try to make prices more equitable among employee groups, it has to

deal with the issue of medically uninsurable. It has to deal with some kind of reinsurance mechanism behind it. It has to do things like that. So, they put on a provider tax. So, what is wrong with everybody paying the provider tax?

Mr. STONE. Well, it is not everyone who pays the provider tax. I submit that the employer was already paying to provide benefits for his employees, and, in all likelihood, the employee contributes to the provision of those benefits as well, through a deductible and co-pay.

When you place the tax on the service provider, the service provider passes that tax back onto the consumer. We are in fact the consumer. So, we are the consumer voluntarily paying to provide benefits, and then we are the consumer paying the tax on the service provider. The next step is to tax, let us say, 2 percent of the total value of everything you have paid out in medical benefits as an employer, pay a tax of 2 percent in addition on that. And when you step back from that and look at your competitor who is not voluntarily providing any benefits, he is getting a great deal in this equation.

So, the ERIC position has been certainly not to discourage increased access and increased coverage for the 37 million, or 51 million, or however many people who do not have any coverage. We are saying that that is a burden to be borne by society.

We are not saying whether you should bear that in terms of a sales tax, an income tax of that, or what have you. But we are saying that it is incorrect to look at the good guy that is the employer plan that is providing the benefits and then aim your ability to fix that system by making it more burdensome for him.

Senator DURENBERGER. Right. Mr. Stone, I do not want to debate the issue. But a tax on providers—which I do not happen to favor—treats everybody the same. It does not make any difference whether it is a self-insured company that is paying the bill, an insured company by an indemnity HMO, or somebody who walks in off the street, gets sick, and has to pay a bill. Everybody is paying it the same way.

I do not like it because it is a tax on the sick. But, leave that aside. Everybody pays the tax. Why should you and your self-insureds be exempted from a tax which is designed to reduce the cost-shifting for underinsured and uninsured persons that you end up paying for anyway, which is part of the design?

Mr. STONE. Because we are already paying for the cost of the benefit that is being provided.

Senator DURENBERGER. But so everybody else. So are these others. The majority of employers are buying Blue Cross, or they are buying some indemnity plan. They are picking it up, too. Why should you be exempted from having to pay this tax? Because, yes, you are covering your employees, but so are they.

You just happen to be choosing, because you are big, the ERISA protection of self-insurance as opposed to the folks who are smaller. They get stuck, in a competitive market for labor, of having to buy an indemnity plan, or a Blue plan, or an HMO.

Mr. STONE. I do not propose that that is an equitable solution to the problem, either. I would agree with you that there is a disproportionate burden being placed either way.

Senator DURENBERGER. You cannot be budged on that. It is just, no, no, no.

Mr. STONE. We also believe that the power to tax the benefit plan creates a great disincentive to provide the plan at all and will encourage employers to simply withdraw providing the benefits, turn it over to the employees to look for their own, which will increase the cost of the system, as a whole.

Senator MOYNIHAN. Mr. Stone, you have not persuaded Senator Durenberger. [Laughter.]

Mr. STONE. We will keep trying. [Laughter.]

Senator MOYNIHAN. And remember who you are up against. There is an old time saying, which is, never bet your kidneys against a brewery. And when you have got IBM, Allied Signal, Federated Department Stores, Bethlehem Steel, Mobil, Motorola, GTM, and that is just the beginning, you know, they will be there when you have finished. But I will leave it to you.

Ms. IGNAGNI. Senator, could I comment on that question as well?

Senator MOYNIHAN. Of course you may. And, Mr. Claxton, would you, too?

Ms. IGNAGNI. In Minnesota, as Senator Durenberger knows, our State Federation of Labor went to the State Legislature with a proposal for broad-based financing and had grave reservations about the surtax proposal that was ultimately adopted. They were not able to prevail in their proposal. And, indeed, in New Jersey, we were not able to prevail; in Florida we were not able to prevail in terms of the initiatives.

Senator MOYNIHAN. Now, help an ignoramus. What does that mean, that you have tried to get and could not get it? Is that something that Mr. Stone wants or does not want?

Ms. IGNAGNI. Well, I cannot speak for Mr. Stone, I can only speak for my own, and I would not have the temerity to do so. I can only speak for my own constituency. But what we would prefer, Senator, is a system that spreads the cost of financing care for the uninsured across the entire population.

We think the fairest way to do that is through the income tax system. There are other ways to do it, obviously, that people have proposed and have debated, and there are pros and cons associated with any particular tax vehicle, or any financing vehicle, and you are having to deal with that here in Washington. What we believe is the hurdle with respect to the State approaches, as well as the national approaches, is the question of whether or not any level of government is willing, today, to proceed to require employers to do their fair share.

If we can get over that, from our perspective, then we are far along down the road toward achieving the kind of access that we want to achieve without the disproportionate financing that would be required of those who are already doing their fair share.

Senator MOYNIHAN. Thank you. Mr. Claxton.

Mr. CLAXTON. Excuse me. If I can just give a quick.

Senator MOYNIHAN. You do not have to excuse yourself. You have been very generous to come before us.

Mr. CLAXTON. I was just listening earlier to Mr. Stone's argument about how the ERISA plans take care of their own, and I thought of an example that someone from the Minnesota insurance

department told me. It was a self-funded employer—I don't remember the name of the city—about 200, 225 people and the employer went out of business, the plan became insolvent.

The insurance department went up to try and help find the people coverage, and 25 percent of them ended up in the State high-risk pool, and you know they were not the 25 percent that were the healthiest of the former employees.

So, I do not think it is necessarily clear to say that ERISA plans are out there all on their own and do not impose costs on the insurance system and on things that States try and set up to help individuals.

Senator MOYNIHAN. Mr. Stone, you have the right of reply.

Mr. STONE. Senator Moynihan, I sort of feel toward that as I do toward Olympic scoring of gymnastics. You ought to discount the lowest score, and discount the highest score and concentrate on the middle. And I think that there are always examples of bad things that happen to good people.

Senator MOYNIHAN. On any curve or any distribution. I guess I am just trying to learn this subject, and am having great difficulty. I do not know why the costs are going up. Obviously, it has something to do with the fact that medicine is getting better.

I guess Lewis Thomas would say that among doctors there is an argument about what point in the 20th century did the random patient with the random disease encountering the random physician prove better off for the treatment. And it turned out to be around 1920, something around there.

But before that, for a long period, physicians had learned not to injure their patients. It took the whole of the 19th century to do that, but they did, and that was an advance. But to help them, besides setting bones, that was very recent.

So, there is an "S" curve here of some kind. I think it is an "S" curve. But, you know, magnetic imaging and things like that; can you do much more after you have done that? Well, there comes a point where you have done all you can.

Government is a problem. This year, for the first time, there are more people working for government than there are working in manufacturing. And government has a terrible disposition to act as if it is providing free goods. And there is no such thing as a free good.

I would think, Ms. Ignagni, that next year will be the 50th year—God have mercy—since I joined the United Steel Workers and the old American Can Co. in Long Island City. And I have seen that labor movement of ours change very greatly. By the end of the decade the majority of the members of the AFL–CIO will be public employees. So, you have kind of a different set of interests.

The public sector is part of your sector, too, and it performs so badly. I was present at one of the moments in American medical history. It was 1955, about March, and Paul Hoake, the newly appointed Commissioner of Mental Hygiene in New York State, comes in to see the newly elected Governor, Averill Harriman.

And he is brought in by the director of the budget and Jack Bingham. And Paul Hoake, a rather heavy Hungarian accent, describes a medication that has been developed by Nathan Klein down at the

Rockland State Hospital. And he synthesized the active ingredient in a vegetative medicinal root called "rauwolfia."

And what he got, was reserpine, the first tranquilizer. And they had been using it clinically, and Hoake was satisfied. He asked Harriman for some outrageous amount of money, like $1.7 million, to start using it systemwide.

And the admissions to New York State mental hospitals continued to rise for 14 months, and then, like an epidemic curve, crashed. It just crashed. There were 94,000 when that meeting took place, and there are 13,000 today. But we could not provide community care; it turned out the community did not want it, and we forgot about it. So, the mental institutions emptied out and the doorways filled up. It is what we call the homeless.

Only we cannot define them as persons who otherwise would have been in the psychiatric institutions; we define them as people who "lack affordable housing." Now, that is a social problem when you cannot see what you have got in front of you. It is called schizophrenia, not rental costs in Manhattan. And, in evidence, they have the same problem in Portland, OR. And, yet, our mental institutions that were there in 1955 are still there.

And the cost per patient is about $180,000 per patient, because the employment has not gone down. How much more of that do we want? A great moment in medicine has turned out to be a nightmare called the homeless, which we cannot define. We have not been able to do anything about it, and we have now got the very sick persons, $180,000 a year per patient. That has nothing to do with medicine, it has got to do with the politics of the public sector.

Are we walking into another one of those? Remember, people came before this committee and I knew who they were. I was downtown with the Johnson Administration, and they said, Medicaid costs about $75 million a year. That is what they told us in this committee. Does that make any sense? You do not have to answer. I was just wandering. [Laughter.]

Mr. CLAXTON. Let me say one thing about what you said. One of the ways to try and address the problems, not only the homeless, but everyone else, in terms of health care, is to give someone the authority to deal with the whole ball of wax.

Karen and I may disagree about whether that should be States or the Federal Government, but I think we are both committed in saying we need to put together one system where you can deal with all of the interrelated problems.

Where I have to disagree with Mr. Stone is in saying that ERISA has created these sort of privileged folks, in a certain sense, and that we should let them go their own way and try and make do with the rest of it. I am pretty sure we cannot solve any of the problems you mentioned, or any of our health care problems if we stay on that kind of system.

Senator MOYNIHAN. We have one more panel. We want to thank you for your courtesy. I will just leave you with a thought. There is a line of the French theologian, George Bananos, who said, "The worst, most corrupting lies are problems poorly stated." Go in peace. [Laughter.]

Mr. STONE. Thank you, Senator.

Senator MOYNIHAN. Thank you all. You are very kind to have come. Now, our final panel, persons well and favorably known to our committee. Mr. Joseph Liu, of the Children's Defense Fund; and Judy Waxman, who is the director of government affairs for Families USA. And we will just follow the order in which you appear. Mr. Liu, good afternoon, sir.

STATEMENT OF JOSEPH LIU, SENIOR ASSOCIATE, CHILDREN'S DEFENSE FUND, WASHINGTON, DC

Mr. LIU. Good afternoon. Senator Moynihan, members of the Finance Committee, on behalf of the Children's Defense Fund, I would like to thank you for inviting us to testify. As you know, CDF is a non-profit charity whose mission is to provide a voice for children who cannot vote, lobby, or speak for themselves.

We have long favored State flexibility in the Medicaid program to improve coverage for low-income Americans. For example, we fully support S. 3212, the Medicaid Eligibility Simplification Act, from Senators Chafee and Bradley, which would allow States to simplify their administrative procedures.

However, we have grave reservations about Medicaid changes proposed in S. 3180, the State Care Act, and S. 3191, the Medicaid Coordinated Care Improvement Act. The importance of Medicaid reforms fashioned by this committee cannot be overstated. The role of Medicaid during this current recession underscores how important the Medicaid expansions have been.

Between 1990 and 1991, the number of poor children in this country increased by nearly 1 million. The number of children with private health insurance decreased by a quarter million. Yet, during the middle of this terrible recession, the number of children without any health insurance decreased. And the fact that the number of uninsured children decreased was simply because of the Medicaid expansions created by this committee.

This morning, the Governors asked to have their hands untied to help their States' children and families. What they did not say, was that Congress has already given them all of the tools that they need to cover every uninsured pregnant woman and child in their State with full Federal financial participation under Medicaid.

An unheralded provision in the Medicaid State, Section 1902 R2, to us tekkies, allows States to cover all the children and pregnant women at any income level. Using this provision, HCFA has allowed Minnesota to cover all of their children and pregnant women with incomes below 275 percent of the poverty level. That is well over $30,000 a year for a family of four.

Similarly, Washington is going to cover all of their poor children using this provision. So, for children and pregnant women, additional flexibility is just not needed. That is why the Medicaid provisions of the State Care Act can only hurt and not help pregnant women and children. Quite simply, to the extent that the bill changes ERISA, we support the bill. Because of ERISA, several courts have invalidated legitimate State taxes on Medicaid providers, and blanket exemptions created by ERISA mean that self-insured plans do not even have to honor things like medical child support orders against absent parents. That is a tragedy that ERISA was not intended to cause.

We agree with the States that Medicaid waivers are needed to cover non-pregnant, poor adults. Children need healthy parents just as much as they need good health themselves. But the State Care Act goes far beyond this. It allows waivers of nearly every protection in the Medicaid statute, including literally hundreds of beneficiary protections.

If State Medicaid utilizations go too high, the bill says, fine, you can slap a $50 co-payment on families earning $300 a month. You cannot find enough qualified providers? No problem. Just waive quality standards for doctors, hospitals, and nursing homes. Tired of being sued for violations of Federal law? Simple. As for a waiver of due process protections.

The State Care bill even goes so far as to waive a provision limiting AFDC cuts. What that has to do with providing everybody in a State with health care reform, I do not know.

On cost containment, the bill is a mystery. It lays out no answers on how to control health care costs, but it imposes very sharp limits on the growth of health expenditures.

Quite simply, we are afraid that the cost containment provisions in this bill will be borne on the backs of poor families, and, quite simply, the lives of children—too many children—are at stake for this kind of broad authority in the program.

The Medicaid Coordinated Care Act also sets aside a number of key protections in the Medicaid statute. The history of Medicaid is simply full of prepaid health plans that deceived and underserved beneficiaries, failed to pay providers, and left the bill for the profiteering with the public treasury.

In Chicago, area HMO's were so poorly structured that the GAO concluded that they underserved beneficiaries. The State did not do anything about it until the Chicago papers ran an expose. In Milwaukee, the contracts were written so poorly, the plans did not provide immunizations to children. In Philadelphia, a profitable managed care plan declared bankruptcy and left $60 million in hospital bills behind them.

Quite simply, we need to have protections if we are going to open the door to managed care in Medicaid, and S. 3191 does not put those protections in place. Instead, it would create a new brand of managed care whose market niche would be the regulatory vacuum created by the bill, and their profits will be based on underserving poor children and women.

In conclusion, I think the committee has to move very, very cautiously before allowing further exemptions and waivers of Federal Medicaid law. The danger of undoing the tremendous progress we have seen in the last 2 years is much too great. If safeguards are not clearly spelled out and assured, these State flexibility bills will cause far more harm than good. Thank you.

Senator MOYNIHAN. Thank you, sir. Very concise and very persuasive.

[The prepared statement of Mr. Liu appears in the appendix.]

Senator MOYNIHAN. Ms. Waxman, forgive my ignorance. I do not know whether we have had you before our committee before.

Ms. WAXMAN. You have on occasion, sir.

Senator MOYNIHAN. On occasion. Well, welcome back, in that case.

Ms. WAXMAN. Thank you.
Senator MOYNIHAN. Please proceed.

STATEMENT OF JUDY WAXMAN, DIRECTOR OF GOVERNMENT AFFAIRS, FAMILIES USA, WASHINGTON, DC

Ms. WAXMAN. Thank you. Thank you, again, for inviting me to testify this morning on both of these very important bills. I want to take a special opportunity right now to thank Senators Leahy, Pryor, and Riegle for acknowledging our interest in the State Care bill in their statements when they introduced the bill, and for wanting to continue to work with us to make it the strongest bill possible.

We are supportive of the concept of providing Federal support for State demonstrations on comprehensive health care. We do, however, have some serious reservations about some sections of the bill, and I would like to talk to you about those.

Although we, of course, agree with everyone else here today that the ultimate health care reform must be accomplished on a national level——

Senator MOYNIHAN. No, no, no. Not everybody agrees. Just for the record.

Ms. WAXMAN. Well, thank you, sir. Mostly everyone, then. It seemed to me everyone I heard make a statement on that fact did say they thought the ultimate decision should be on a national level. But, of course, some States do want to tackle the crisis, and we think that they should be encouraged.

The stated goal for the States that want to initiate reform, is to ensure that every citizen has access to affordable health care coverage. And, yet, the measurable goals that are in the State Care Act for the demonstration projects will not assure affordable health care for all. The cost containment goals in the bill are clearly stated, and, if States could meet those particular numbers, they would contain their health care costs.

However, the goal for coverage contained in the bill falls far short of the goal of universal coverage. It sets up two alternatives. One, would be that 95 percent of the population must be covered, and the alternative goal would be an increase of 10 percent of the eligible State residents served over the percentage of people currently served. Now, we can understand why 100 percent might be a little bit unrealistic to meet. However, the alternate goal of only an increase of 10 percent is a severe problem.

I want to reiterate what Governor Chiles said, that States really cannot achieve one of these goals without achieving the other. You cannot contain costs unless you have virtually everyone covered. Unless everybody is contributing to the system with premiums and you eliminate uncompensated care, you will not be able to control health care costs. This is a major concern of ours that must be addressed as the bill moves forward.

Our second major concern involves the waivers. We recognize that there must be waivers from some Federal laws to implement these State reforms, and we are in support of the ERISA waivers for the narrow purpose as stated in the bill, and the Medicaid waivers. We are concerned, however, with the potentially broad latitude allowed for waivers in the Medicaid program.

We know that some of the sponsors of the bill want to fulfill their original intention to protect some of the most vulnerable Medicaid beneficiaries, that is, those who are mandatorily eligible. But I want to point out that half of the people on Medicaid are on the program now at the option of the State, and these people are no less vulnerable than the mandatorily eligible population and should indeed be protected.

Senator MOYNIHAN. That is a nice number.

Ms. WAXMAN. About half. Yes.

Senator MOYNIHAN. About half? A State can say, we will take over this additional group and that group, as against the compulsory groups?

Ms. WAXMAN. Right.

Senator MOYNIHAN. Nice number.

Ms. WAXMAN. We questioned the need, too, to allow waivers of just about every plan provision in Medicaid. Many of these provisions that have been negotiated over the past 27 years protects States, as well as the beneficiaries.

Such things as protections on confidentiality, requirements for nominal co-payments, requirements for provider licensing and certification, are among them. We think the breadth of the State Care language allows too many changes, and must be reviewed and must be narrowed.

Our third concern is with the benefit package. There are two minimum benefit packages that are articulated in the bill. One, the standard package, we do believe, would be an adequate minimum package. The so-called basic package, however, is really a bare-bones package which covers extremely limited benefits, there are no restrictions on cost sharing, and no amount, duration and scope requirements.

We are afraid that people who would be covered by this basic benefit package may, indeed, be worse off than if they had no coverage at all, because they will be paying premiums for something that they may never actually get to see any benefit from. We think that the basic benefit package must be eliminated as an option.

Our fourth concern is about cost-sharing protection for low-income people. There is nothing articulated in the bill that would protect low-income people from having to pay insurmountable out-of-pocket costs. Both minimum benefit packages, even the more comprehensive one, has cost-sharing requirements that would just be impossible for many low-income families.

The 20-percent premium requirement, $700 deductible and 20-percent co-insurance may seem reasonable for some middle class people, but it could mean that the low-income family is charged with paying amounts of money they simply cannot afford.

We think that financial protections for low-income people should be included in the bill. We do want to continue to work with the members of the committee to make the bill strong, because we think there can be some potential here to help millions of Americans, if it is done properly.

We have also been asked to address your bill, sir, the Medicaid Coordinated Care Improvement Act, and we commend your interest and commitment to want to increase access to affordable quality

care for Medicaid beneficiaries. But I do have to say, we have a lot of concerns and doubts about the way the bill is structured.

We have a basic concern that the incentives in managed care plans for Medicaid beneficiaries is different than that for the general public, and that there are incentives inherent in the way these plans are set up to underserve the Medicaid population. So, we look at the plans skeptically. We wonder how States will be able to save costs significantly over what they are already paying providers.

Senator MOYNIHAN. Well, can I just say that we are going to have to close down now. The time that we can meet has passed. We would be very disappointed if you did not start out with a skeptical view of anything that comes before you.

[The prepared statement of Ms. Waxman appears in the appendix.]

Senator MOYNIHAN. Can I ask both of you—the Children's Defense Fund and Families USA—give us your concerns in specifics with respect to the statute, and tell us how you would like it to read. If you think you can fix it, or you do not think you can fix it, say so. Will you do that?

Ms. WAXMAN. Well, let me say, on the Coordinated Care Act, we think there are a lot of consumer protections which could be included in the bill.

Senator MOYNIHAN. Yes.

Ms. WAXMAN. And we keep hearing this morning about a lot of——

Senator MOYNIHAN. Well, if you think so, give them to us in writing. This hearing is about to close. We would like them. That is how we draft, we see something in front of us.

Ms. WAXMAN. Right.

[The information appears in the appendix.]

Senator MOYNIHAN. Mr. Liu.

Mr. LIU. The simple answer on the managed care bill is that, when managed care works—if it works—it is because there is competition for enrollees. The Medicaid Managed Care bill mandates beneficiaries to enroll with the plan. And under that circumstance——

Senator MOYNIHAN. That is not competition, in your view.

Mr. LIU. There is no competition for quality. So, we would want that provision taken out.

Senator MOYNIHAN. Well, I certainly know that I would like to see that. Senator Pryor, I am going to turn this over to you. We have had some marvelous testimony; some people who are very skeptical of our proposals, and we think that is very good.

Senator PRYOR. Thank you, Senator. Well, I want to apologize to Senator Moynihan. I was due here at 1:30 and I got detained a little bit there. But we appreciate very much both of you appearing before us today. I understand that there are some concerns that you have and that you have expressed at the hearing this afternoon.

I wonder if you might be so kind as to share with the committee, for our record, maybe any constructive thoughts you might have of how we might strengthen what we are proposing to do. I think you know what our concept is. I wonder if you might share with us

what you think we should be about at this time to strengthen our proposal.

Mr. LIU. Absolutely. I think the goal that we both share is to cover all of the States' uninsured residents. And the way to do that with Medicaid waivers is to allow States to cover groups they cannot cover now. Right now, they cannot cover non-pregnant adults, and, quite simply, we would want this bill to give States that flexibility.

But we have to narrow the waiver from any protection in the Title 19 Act down to the waivers needed to bring in those additional persons and to bring in payment to cover those people. That is the simple answer and we think that is consistent with the goals that you stated for this bill. And, if that change was made, we would be glad to support the bill in its entirety.

Senator PRYOR. Do you have any idea what resources—I guess I am talking about manpower, and I asked this question a little earlier of our four Governors—what sort of manpower on the State level is being utilized today on behalf of the States to sort of comply with the Federal regulations and mandates?

Mr. LIU. Well, with Medicaid, the administrative costs are actually very small. They are about 5, 6 percent of total Medicaid spending, and that is far less than private health insurance. So, we think that the burdens of Medicaid mandates, in terms of administration, are relatively small in comparison to what goes on.

Senator PRYOR. Ms. Waxman, you, I think, have already given your statement. Is that correct?

Ms. WAXMAN. Yes.

Senator PRYOR. I am sorry I did not get to hear it. Do you have any suggestions, in addition to those by your colleague, that you might leave with the committee on how we might strengthen this?

Ms. WAXMAN. Yes. We have four concerns, let me just very briefly say. I have kind of narrowed it down. One, actually piggy-backing on what Governor Chiles said, that you really cannot contain costs unless you cover everybody, the demonstration plans here for this bill does not require universal coverage. In fact, it requires far less. That is one major concern.

Another one is the benefit package. There are two minimum benefit packages in the bill. One of them, the basic benefit package, is very minimal. It has no cost-sharing requirements, no requirements for amount, duration and scope. So, we are very concerned about that second minimum benefit package.

We think there should be waivers from Federal law, but we think the Medicaid waivers are over-broad. They should be looked at and narrowed. The whole program does not have to be waived in order for a State to do comprehensive reform.

And the fourth one is, no financial protections for low-income people are, as yet, in the bill, so that people whose incomes are under poverty, for example, could be asked to pay enormous sums that they cannot currently afford, and we hope that will be changed as well.

Senator PRYOR. One final question. I asked the Governor of Vermont this question. I asked him, if we go forward with something like the Leahy-Pryor bill, are we basically slowing down reform on the Federal level?

Do you think the Federal Government is going to say, well, the States are now going to try it awhile and so we, the Federal Government, will back away? The Governor of Vermont answered me—you may have been in the audience at that time—that, no, he thought it would speed up the reform on the Federal level. I wonder if you have a thought on that, either one of you.

Ms. WAXMAN. Well, we, of course, would prefer that national reform pass yesterday. But besides that, I think the history of this country is that reforms do often start on a State level. Many health care reforms, in fact, have started that way. So, we certainly think it could not hurt to let the States experiment and prod the Federal Government into action. We might learn something from them.

Senator PRYOR. Mr. Liu, do you have any comments?

Mr. LIU. Yes. From our perspective, the whole reason that Medicaid has expanded for pregnant women and children is because the States wanted to move ahead and do that. So, our experience shows that when we make changes, if they are carefully crafted, it can work. But I think we need to be very, very careful about how we take the next steps.

Senator PRYOR. Well, 6 months ago I would have dared to say that this hearing would not have taken place this year, that there would not have been much steam generated for giving the States a great deal more flexibility in having their own health care programs.

But, as things developed during this session of Congress, or, let me say, as things did not develop, it looks like the States gathered more momentum. They had four great leaders—four of their Governors from earlier today—who did a splendid job. They have made, I think, a good case. We are going to take your concerns into consideration as we move forward into this field, and we want to thank both of you.

The Families USA, the Children's Defense Fund are both outstanding organizations that we look forward to working with in the future, and we certainly have enjoyed working with in the past. So, with that said, we will adjourn our meeting.

Mr. LIU. Thank you.

Ms. WAXMAN. Thank you.

Senator PRYOR. Thank you very much.

[Whereupon, at 1:42 p.m. the hearing was concluded.]

APPENDIX

Additional Material Submitted

Prepared Statement of Senator Daniel K. Akaka

Mr. Chairman, I heartily commend you and the Finance Committee for holding this hearing on state health care reform initiatives. As Congress crafts legislation to extend health care coverage to the over 35 million Americans currently without health insurance and to improve coverage for the additional 60 million with inadequate insurance, the experience of states is most instructive.

Some states are primed to forge ahead with health care reform plans. I am pleased to say that Hawaii is one such health pioneer which has taken a giant leap forward in the field of health care.

Hawaii has had a longstanding commitment to make health care available to all its citizens, and we have reached near universal coverage. Because of our commitment to health care, Hawaii ranks among the healthiest states based on indicators such as low infant mortality, low hospital utilization, and low chronic disease rates.

With over 35 million Americans lacking health insurance, the federal government clearly is not fulfilling its responsibility of guaranteeing access to health care for all Americans. At the same time, however, the federal government is not doing enough to assist states like Hawaii, which have not waited for Washington to act and have achieved near universal health coverage through their own initiative.

The cornerstone of the health care system in Hawaii is the Hawaii Prepaid Health Care Act of 1974. Nearly two decades ago, at a time when the federal government was only beginning to wake up to the problems of our health care system, the State of Hawaii was boldly moving forward by requiring that employers provide certain basic health care benefits for their employees.

The Hawaii statute is the first and only such mandate in effect. Over the years, the state has continued to refine and improve this system. Regrettably, the federal government has often been the greatest obstacle to allowing Hawaii to expand and improve its system of universal health coverage.

Under the Employment Retirement Income Security Act (ERISA), states like Hawaii are precluded from imposing minimum health care requirements on employers without a specific exemption from the act. Legislation which I introduced to provide Hawaii such an exemption was enacted by Congress in 1983. Unfortunately, Congress only permitted the state to require the specific health benefits set forth in its 1974 statue.

Consequently, this landmark law has been frozen in time. In order for the Hawaii Prepaid Health Care Act to retain its limited exemption from ERISA, no substantive changes can be made in the act.

Eighteen years have passed since this legislation became law, and there is an urgent need to bring it up to date. Dependent coverage, alcohol and substance abuse treatment and the balance of premium contributions between employers and employees are major areas need to be addressed.

Hawaii is not immune to problems of rapidly increasing health care costs and inequitable distribution of care. Hawaii faced a first-time $64 million shortfall in state Medicaid expenditures last year, which it met with state revenues, and estimates point to a 20% shortfall for the current year. Despite having among the lowest health insurance premiums in the nation, Hawaii businesses are struggling to pay for their employees' coverage. And, as is the case across the country, our residents have trouble getting care in some rural communities.

I have introduced a bill, S. 590, which would exclude the Hawaii health care statute from ERISA. Such an exemption would give Hawaii greater flexibility to improve both the quality and scope of health care coverage for its working men and

women. It would also allow the state to eliminate inconsistencies in its innovative approach to health care.

Mr. Chairman, at this point, I would like to submit for the record written testimony by John C. Lewin, M.D., Director of the Hawaii State Department of Health. Dr. Lewin highlights the federal obstacles to state health care reform. He also comments on S. 3180, the "State Care Act of 1992," of which I am a cosponsor, developed by our colleague from Vermont, Senator Leahy and a member of this Committee, Senator Pryor.

The American public and many of us in Congress recognize that the federal government has neglected the health of millions of Americans. However, while we fashion and debate comprehensive strategies to close the nation's health care gap, we must not overlook more modest initiatives, such as S. 590 and S. 3180, which would allow states like Hawaii to expand and improve innovative health care programs that have a proven record of success.

As we move toward national health care reform, I have an apprehension. Hawaii has a system in place which came into being through the cooperation and vision of providers, consumers, insurers, businesses, labor organizations, government officials and policymakers. I would not want to see this functioning system—one that has resulted in 98% coverage—be abruptly supplanted by another system which would leave Hawaii's people with less health care than they enjoy today.

Mr. Chairman, Hawaii's experience has much to offer in this discussion of how to reform health care. I ask you to approve legislation to allow Hawaii to continue to be a pioneer in health care innovation.

[Submitted by Senator Akaka]

STATEMENT OF DR. JOHN C. LEWIN, M.D., DIRECTOR,
HAWAII STATE DEPARTMENT OF HEALTH

Chairman Bentsen and members of the Finance Committee, on behalf of the State of Hawaii we appreciate this opportunity to submit for the record comments on obstacles to state health care reform and to comment on an important piece of legislation currently before the Committee, S. 3180, the State Care Act of 1992. We commend you for holding this important hearing.

This Committee, and indeed Congress, is very aware of the problems regarding health care in America today. The statistics are staggering. Thirty-six million Americans lack health insurance and each year affordable health care moves beyond the reach of more and more Americans. Today, health care costs encompass about 14 percent of our nation's gross national product.

Clearly, the time has come for aggressive action. Congress has before it a host of bills dealing with both comprehensive and incremental solutions to the health care crisis. The Administration has come forward with a package of incremental changes as well. Each day that Washington fails to enact reform measures is a day closer to a health care system that only the wealthy can afford. The American people need movement now, on some sort of health care reform. Without a legislative solution, more and more people will awake to a new morning without health care coverage, and the cost of health care will only continue to skyrocket.

If Washington is unable to agree this session on health care reform, then states must be given the tools to solve their own problems, for nowhere in our federal system is the impact of the health care crisis being felt any more than at the state government level. As major providers of health care coverage for the poor and unemployed, states are affected most directly by the crisis. Even in the "Health State" of Hawaii, with arguably the best health care system in the country, our citizens and our government are being severely impacted by this crisis. Recent estimates show that the State of Hawaii will experience a 20% shortfall in State Medicaid expenditures for the current year. This comes on top of a $64 million shortfall for which State revenues had to be found last year.

Hawaii, as the only state with an employer mandate, is the only state with an intimate understanding of how it works. We are the only state that offers its residents near-universal (98%) access to health care coverage, and are now in a position to move beyond the issue of access and to focus on equity and cost-containment. After 18 years experience, we know why, despite our high cost of living, Hawaii has among the lowest health insurance rates in the nation, and why, despite significant high-risk populations, we have among the best health status.

The success of our health care delivery system is not due to genetics, lifestyle, or weather. Our success is due to our employer mandate, the flexibility that our statutory ERISA waiver has, in the past, provided, and to the cooperation and foresight of insurers, providers, businesses (big and small), consumers, and policy makers. It is founded in a constant effort and long-standing commitment to providing Hawaii's residents with affordable, high-quality health care.

Ironically, this investment of resources and effort puts Hawaii in a precarious position, relative to other states, as Congress reflects on national health care reform. Because we have advanced the furthest, we potentially have the most to lose in the implementation of national reform legislation. As national health policy develops, we urge that not only our experience and how it may contribute to the debate be considered, but also the high stake that Hawaii has in these deliberations. We are in very real danger of being set back by national reforms and we urge you not to detract from those aspects of Hawaii's system that work well, not to undo what so many have strived so hard to build. Instead, support us in making it better. There is room in the federal system to provide Hawaii the opportunity to build on our experience and momentum by allowing us to continue to be fertile ground for innovative health care reform. To do so will, we argue, accrue to the benefit of other states and the national health care reform movement.

It is in this context of preserving what we have and providing us the continued opportunity to make what we have better that we are pleased to provide comments on S. 3180, the State Care Act of 1992.

S. 3180. State Care Act of 1992

The State Care Act of 1992 proposes to give states flexibility so that they may craft unique solutions to address the specific health care needs of their population. S. 3180 is a response to states' cry for regulatory relief, and is founded in the faith that states, given freedom and federal support, and motivated by the welfare of their residents, will develop effective solutions to complex national problems.

While we are proud of the successes and innovations of Hawaii's health care system, we have long been aware that much work still needs to be done. Like the rest of the nation, astronomical increases in health care costs threaten Hawaii's economy and jeopardize the well-being of our residents. Like the rest of the nation, Hawaii's businesses are struggling with the burgeoning costs of providing health coverage to their employees. Like the rest of the nation, Hawaii has been unable to control our soaring Medicaid budget and, in some rural communities, our residents have difficulty getting care. This is our challenge and our call to action for health care reform.

For the past two years, Hawaii has been studying improvements to its health care system. In 1990, we convened a Blue Ribbon Panel, composed of business, labor, consumers, and providers, to study and assess Hawaii's health care delivery system and submit a plan of action that will innovatively and

successfully take Hawaii's system into the 21st century. We have also convened a sub-cabinet health care reform task force to develop a comprehensive package of specific health care reforms and to effect, upon legislative approval, these reforms in Hawaii. This task force is composed of representatives of various state departments and agencies that have an interest in health care and health care delivery. We have been closely monitoring national health care proposals, as well as studying the experiences and efforts of other states. In January, we hope to submit a package of health care reforms to the State Legislature for their approval.

Because of our interest in enacting further health care reform within our state and because of our strong belief that we can contribute to the development of a national proposal, Hawaii has been an active participant in the development of S. 3180. In working with the National Governors' Association and our Congressional Delegation, we have been involved in the drafting, support, and progress of S. 3180. We believe that Hawaii would be an ideal candidate for a State Care demonstration project grant. Not only would we be poised to embark upon reforms, but we could also make a significant contribution to the State Care effort. While other states struggle with expanding access, we could build upon our access and experience, allowing us to move forward with an innovative, quality-based, and cost-effective system of care. Our further experience would be of value to the nation, and specifically to the recommendations that the Commission would be required to submit after five years.

Having expressed our continuing commitment to reform at the state and national levels, we would like to offer the following specific comments on the legislation:

- All states are confronted with the pressure to meet the health care needs of their people, and we anticipate that more than 10 states will seek demonstration project grants. If this is the case, the State-Based Comprehensive Health Care Commission may be confronted with a very difficult task: that of choosing from among many state applicants, with an equally pressing need for reform, with equally meritorious and valuable proposals, all of which represent the ethnic, geographic, and demographic diversity of our country. We believe that the number of demonstration projects must better accommodate the need and diversity of states. Especially those, like us, which have enacted comprehensive reforms. We are concerned that, despite our interest, we may be left out of the small number of states permitted into the demonstration project because we are so far ahead in the reform process. Ensuring that states at a more advanced level of reform are included in the demonstrations is important; not only to us, but to the overall reform process at the national level. We therefore recommend increasing the 10-state limit and clarifying the selection criteria to ensure that states already implementing reforms will have a priority consideration in the awarding of demonstration project grants.

- The standard benefit package (SBP) caps individual premium contribution at 20% of premium value. Under Hawaii's Prepaid Health Care Act, employees are required to pay 1.5% of wages or up to 50% of premium cost, whichever is lower. Employers are required to contribute at least 50% of the premium for their employees. While we would like to adjust the specific cost-sharing levels in our own program, the basic principle has worked well for Hawaii, and is more equitable for low wage earners. We would request that the SBP include flexible options for a wage-related individual premium contribution.

- Under the proposed standard benefit package, it is not clear what standards will be used to determine what is medically necessary or medically accepted care. We are particularly concerned that the wording currently in the bill implies that unlimited amounts of care be included as part of the required package. We believe that this is not cost-effective or necessary for good coverage. Our own standards, for example, entail 120 days of hospitalization--which we feel is quite adequate for inpatient coverage. It is not clear if states would determine their own standards or whether the Commission would develop standards. We hope that the model benefits package to be developed by the Commission will clarify this ambiguity.

Finally, a word on perhaps the largest impediment to further improvement of our health care system--ERISA. In the ten years since our statutory ERISA waiver was put in place, we have found that a state needs access to information on employer plans which are providing coverage to its residents. Without this information, states will have a difficult time enforcing businesses to comply with ERISA. We would urge consideration of provisions which permit states to require reporting of employee benefit plans, or, at a minimum, provide states with access to the information that ERISA plans already are required to file with the Secretary of Labor, with flexibility to require other necessary additional information. This provision should not apply only to fully-insured employer plans, but also self-insured, MEWA, and multi-state plans that are providing coverage to state residents. States need this information to monitor compliance with their state programs, and to ensure that self-insured and multi-state employer arrangements are providing quality care to their beneficiaries and are meeting benefit package value and other applicable requirements. States must also have the authority to enforce against delinquent or non-complying employers or insurers. Hawaii's 18 year experience with an employer mandate, and 10 year experience with an ERISA waiver can attest: monitoring and enforcement capability at the state level are essential to the successes of any employment-related health care program.

We have been working with Senator Akaka in developing a measure which suits our needs and would welcome the opportunity to develop appropriate language for the Committee's consideration this session.

Thank you for your consideration of Hawaii's comments on S. 3180. We look forward to further discussion of this and other health care reform measures. The American people are gravely concerned about health care costs and services, and it will take our best creative efforts and continued cooperation if we are to deliver meaningful reform. Together we can succeed but we must be ready to make some tough decisions, and we must do so now.

Hawaii joins you enthusiastically in this effort.

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PREPARED STATEMENT OF SENATOR MAX BAUCUS

Mr. Chairman, I am very pleased to attend this hearing today. Health care costs are skyrocketing out of control and millions of Americans can no longer afford basic health insurance. In the absence of federal action on this issue, many states are moving to enact their own health reform plans. I, strongly believe that states should have the authority to implement comprehensive health reform.

In my own state of Montana, health care is the fastest growing section of the state's—budget. Yet even though we spend more each year on health care, fewer and fewer Montanans can afford health insurance premiums. Almost 20 percent of our state's population has no health insurance.

I recently organized the Montana Citizen's Health Care Group to develop a comprehensive Montana, solution to this crisis. I expect their recommendations soon. But I worry that federal laws will prevent Montana from implementing their suggestions. Montana would not be the first state to write a bold and innovative health reform plan only to find that federal law denies states the authority to implement it.

For this reason, I have am cosponsoring S. 3180, the State Care Act of 1992, introduced by my colleagues Senators Leahy and Pryor. This legislation would give states the authority to implement health reform by giving them a waiver from certain federal programs. However the requirements for a waiver are strict. The state's reform plan must be comprehensive and must meet strong access and cost-containment goals.

While I am very pleased with most of S. 3180, I am concerned that it fails to give states full authority to control skyrocketing costs. The legislation allows states to include Medicare in a rate-setting system for hospitals, but not for other health care providers. I believe states need the authority to include the entire Medicare program in their cost-containment—plan.

It's a mistake to allow federal laws to impede meaningful state reform efforts. The federal government should encourage and facilitate state action. Today's testimony will help us meet that goal. I would like to commend the Chairman for holding these hearings.

PREPARED STATEMENT OF GOVERNOR LAWTON CHILES

Chairman Bentsen, Senator Packwood, and members of the Committee.

Thank you for inviting me here today to speak about the nation's pressing need for health care reform. I would also like to talk about the early progress we have made in Florida in attempting to work out a health care solution for our residents.

Let me begin by stating that we'd prefer a national health care solution. I share the opinion held by many that national health care reform has become an absolutely essential part of the American agenda--and that the longer we delay, the more difficult it will be to come up with a workable plan.

As you know, I called upon Congress and the Administration to move quickly to enact national health reform legislation when the National Governors' Association met in Seattle last summer. At that time, I stated that while we would prefer a national solution to our health care cost and access problems, the states can no longer simply wait for the federal government to act. Today in Florida, we have two-and-a-half million people who are uninsured. We would be neglecting our responsibility to our residents if we were to tell them that we won't be able to help them until a national health plan is enacted.

The problems in our health care system are deep and complex. As challenging as they seem, they'll almost certainly get worse if we don't deal with them now. Our population is aging and placing increased demands on our limited resources. Our great clinical capabilities are extending the lives of many, but with an ongoing dependence on extraordinarily expensive technology. The successes of the past few decades have led us into uncharted territory. If we continue down the present path, it won't be long before the costs of the system drive us to the moral and ethical dilemmas of rationing. This is something we can and should avoid.

Most individuals are insulated from the impact of these developments by their comfortable insurance policies. Health insurance is like a mattress that cushions us from the hard, cold bedrock below. Still, an increasing number of individuals are finding that when chronic or acute illness makes them need it most, the mattress is pulled away. Similarly, businesses understand that premium increases cannot continue at current rates without some modification of benefits.

Florida is one of a handful of states that have passed a comprehensive health care reform law. Like other large states with diverse populations, we face unique and difficult challenges.

- As the fourth largest state in the nation, almost 19 percent of our population is uninsured.
- We have the third highest non-elderly uninsurance rate [22.9 percent] compared to 16.6 percent nationally.
- Fully 75 percent of Florida's uninsured are workers or their families. One-quarter are low-income, unemployed persons. Sadly, one-third are children.
- Fifteen percent of all Floridians live in poverty.

Despite numerous improvements in our publicly sponsored health programs, Florida still ranks among the lowest states in overall indicators of residents' health. We rank 30th among the states in infant mortality rates, 39th in low birthweight babies, and 3rd in the number of AIDS patients.

Part of Florida's uninsurance problem can be explained by the characteristics of our business community. Large businesses are more likely to offer health insurance as a fringe benefit than small businesses. But 95 percent of Florida's businesses employ fewer than 25 people. Among firms with 5 to 9 employees, almost one-third are uninsured. In even smaller firms (those with fewer than 5 employees), 60 percent are uninsured.

Almost 49 percent of Florida's work force is employed in services or retail trade occupations--two of the commercial sectors least likely to offer health insurance. Increasing unemployment also adds to the rolls of the uninsured. Florida's 8.9 percent unemployment rate is well above the national average. Recent layoffs by employers who typically offer health insurance, such as banks, airlines, and government also contribute to the state's burgeoning uninsurance problem. And of course, all of you in the past few weeks have witnessed the massive devastation in Dade County caused by Hurricane Andrew. Once the wreckage is cleared, the hidden problems such as damage to businesses, additional unemployment, and lost health insurance coverages will emerge.

The cost of care is another major contributor to our health care problem. Last year, we spent almost $32 billion on health care in Florida. Without major reforms, we expect to spend more than $90 billion by the year 2000. Even for those who have health insurance, out-of-pocket costs are threatening their access to care.

All of you know what the escalating cost of health care is doing to business:

- American health care costs made up 11.6 percent of the gross domestic product in 1989, compared to 8.7 percent in Canada, 6.7 percent in Japan, and 5.8 percent in Great Britain.
- If health care costs are not controlled, the nation will spend $1.6 trillion for health care by 2000, which will be 16.4 percent of the gross domestic product, compared to 5.3 percent in 1960.
- Nationwide, employers' health care costs increased 46 percent between 1980 and 1990. Projections for the 1990s show continued sharp price increases.
- Health benefit costs now amount to 37 percent of net company profits.
- If costs continue to increase at the current rate, the annual cost of providing medical benefits will exceed $22,000 per employee by 2000.

Rising health care costs, increasing numbers of employers that do not offer health insurance benefits, insurance practices that prevent people from getting coverage or keeping it, and inadequate protection for those who do not have coverage are some of the factors that contribute to Florida's health access problem.

I understand, as I'm sure you do, that there is no silver bullet for health care reform. States that have gone ahead and committed themselves to full access find their path even more treacherous because of lingering tight economic times. But the same holds true for the federal government, and it may just be that the best way to build a bridge towards national health care reform is to encourage states committed to full access and comprehensive reform to test the real world complexities that make the task so difficult.

The courageous, forward looking reform efforts by the State of Oregon illustrate my point. Even though they approached the task slowly, methodically, and in full public view, their efforts were ultimately stopped by special interests that persisted in their opposition to reform. But I believe that this is a temporary setback. I suggest to you that it won't be long before we look back at the pioneering efforts of the Oregonians and realize their contribution towards the health care of the future.

Each of the major national proposals has promising elements. Senator Mitchell's plan establishes a new federal program that guarantees basic health care for all Americans, maintains the employer-based insurance system, and eliminates ties between federally supported public assistance and medical assistance programs. The American Hospital Association's approach emphasizes private coverage through the workplace, establishes a basic benefit floor for all public and private health plans, proposes important private insurance reforms, and offers an innovative proposal to fundamentally restructure our health systems through the establishment of community care networks. The American Medical Association would extend public coverages to all those with incomes below poverty, expand long-term care financing, require employer coverages of full-time workers, pioneer the use of practice parameters to ensure only high quality care is provided, and through ERISA reforms subject self-funded and commercially insured plans to the same state regulation. The Health Insurance Association of America proposes sweeping small business reforms, expanded public coverages for the poor and the near-poor, and recommends a variety of cost control measures. Governor Clinton's plan offers a new covenant for change, guaranteeing universal coverage; reinventing our delivery system through the use of group care health networks; controlling costs and improving quality through the reform of private health insurance, limiting cost increases, eliminating waste, controlling the spread of new technologies, and other measures; expanding long-term care coverages; improving primary and preventive care services; and intensifying health education efforts.

But the fact that we still fall short of a broad consensus tells me that perhaps the best first step to a national reform plan is to give us the flexibility, and in a couple of years we'll be able to return to you with a higher level of understanding about just what it will take to implement national health care reform. This is a workable compromise that offers the best way out of the health policy gridlock that seems to grip us so tightly.

Knowing that past national reforms efforts have failed when they were launched during slow economic periods, wouldn't it be best to test access, cost control, utilization, and small business insurance reforms at the state level? I say it would.

I'd like to compliment my colleagues from Hawaii, Minnesota, South Dakota, Vermont and other states for providing leadership in this area. As you know, Hawaii is the only state in the country that has achieved virtual universal access to health care, while containing costs. Their commitment to universal coverage is reflected in their low infant mortality rates and the above average health status of their residents. They have only been able to achieve this, however, because of a federal exemption from the ERISA preemption that they secured in the early 1980s.

Minnesota and Vermont have also taken the bull by the horns and moved ahead to make sure that all of their residents have access to health care. Minnesota has done this through its Health-Right program, and Vermont has created a new health care authority to develop its plan.

I would personally like to thank Governor Romer for his fine work on health care reform for the National Governors' Association.

In March I signed into law Florida's Health Care Reform Act of 1992. This legislation includes our comprehensive health care reform proposal--the Florida Health Plan--as well as a set of health insurance reforms targeted at the small employer market. The legislation enjoyed wide bipartisan support in both houses of the state legislature, and it also gained the support of many provider, employer, and consumer groups. In fact, a recent issue of Florida Trend magazine ran a story about the state's new health care law. The title of the story was "Business Applauds Health Reforms."

I have no illusions about our initial success in passing this legislation. I feel a little bit like a boxer who has won round one--with eleven more rounds to go. There are bound to be plenty of punches ahead.

Our goal is to ensure that all Floridians have access to a basic health care benefit package by December 31, 1994. Ultimately, we foresee a system in which every Floridian will have a family doctor who serves as the gatekeeper to a managed care system. Though we recognize the difficulty of our mission, we also understand the costs of continuing to delay the implementation of fundamental health care reforms.

The new law contains several important provisions to help us achieve our goal. It creates a new Agency for Health Care Administration that consolidates health planning, financing, purchasing, and regulatory functions into a single organization. This agency will spearhead our reform effort.

In Florida, we're taking a somewhat different approach from the other states pursuing comprehensive reforms. We know that most Floridians prefer a largely private, employer-sponsored system of health insurance coverage. Instead of beginning by committing state government to covering all Floridians, we've issued a challenge to the private sector to work with us as a partner and develop a road map to a comprehensive solution.

President Bush said recently that a government-run health care system would have all the efficiency of the U.S. Postal Service and the compassion of the KGB. And while I find the President's characterization grimly overstated, I admit that if we have an option, we would all want a system centered on personal choice of providers with little intrusion between the patient and the physician. The question is, can we still pay for what we want? The only way to answer this question positively is to recognize the depth of our problem and to commit ourselves to working together for solutions.

We will test this approach by creating a Voluntary Private Health Insurance and Cost Containment Program that began in July and will run through December, 1994. The state will establish health coverage and cost containment targets to measure the program's success. This critical piece of our reform effort allows the state to join with the private sector to show that a public/private partnership can solve the problems of accessibility and affordability without major government intervention.

It should be clear, however, that we are in a very, very difficult situation. Whatever path we choose, there is no easy way out. All meaningful reform must rest on a basic foundation of support for business growth, profitable businesses, and adequately paid employees. The current erosion of wages and jobs is clearly not acceptable. Our strong support for this partnership rests on our confidence in the ingenuity of the private sector.

We in government are going to be doing our part to help the partnership work. We're reforming the small group insurance market, developing a Medicaid Buy-In program, and expanding successful programs for the uninsured.

The small business insurance reforms include:

- creating basic and standard benefit plans,
- requiring insurers to guarantee issuance of plans,
- prohibiting certain underwriting practices,
- implementing a 12-month limit on exclusions due to pre-existing conditions,
- eliminating denials and non-renewals of small employer plans because of health status, claims experience, occupation, or geographic location,
- and implementing restrictions on premium increases.

Florida will also develop a basic benefit standard that will become the floor for all public and private insurance plans in Florida. It will include all essential health services, emphasizing primary and preventive care delivered through a managed care system.

We're also looking at ways to expand the Florida HealthAccess Program for small business employees and their families, by developing a strategy to decrease the current level of premium subsidies, improve the group's negotiating and purchasing power, and refine the use of managed care plans.

The pooled purchasing cooperative for public sector employers will extend its services to the private sector to aid them in getting the maximum benefit from each health care dollar.

Other parts of the Florida Health Plan address additional problems in the current system. The Florida Health Services Corps will trade state-funded scholarship and loan assistance for students in certain health professions in return for a commitment to practice in medically underserved areas. We will also establish a comprehensive health promotion program to help Floridians achieve and maintain better health--in part to promote increased personal awareness and a stronger commitment to the role of individual responsibility for good health.

You should also know that earlier this year I signed the Patient Self-Referral Act that specifies the narrow conditions under which physicians can refer their patients to facilities where they are major investors. For certain facilities, such as diagnostic imaging centers, clinical laboratories, and physical and radiation therapy facilities, patient self-referrals are banned. It is estimated that these restrictions will save $200 million annually. This law is being challenged in the courts, but I am committed to successfully defending the state's right to protect its citizens from unnecessary costs.

We must do even more. Increasing health care costs pose a serious threat to fully insuring our population and the affordability of even basic health care. I firmly believe that insuring all our citizens is the first step. By doing this, we will eliminate the cost-shifting that is undermining our private insurance system. It will also allow patients to get care when they need it, avoiding the higher costs associated with treatment delays.

At the same time, however, the public and private sectors must mount an aggressive campaign to curb health care cost increases. Florida will pursue a number of strategies, including:

- establishing statewide global expenditure limits,
- instituting tighter market entry controls,
- promoting the use of managed care,

- controlling the spread of high-tech services,
- enacting additional regulatory reforms to simplify billing, reduce insurers' overhead costs, and maximize the purchasing power of third party payers,
- implementing practice parameters to ensure the proper use of services,
- and assessing further medical malpractice reforms to reduce the insidious effects of defensive medicine.

I'm a great believer in the free market, and in the use of incentives over mandates. But if we are to provide these incentives, I need your help and additional flexibility.

We're designing a Medicaid Buy-In program for people with incomes up to 250 percent of the poverty level. To implement our buy-in program, we need Congress to remove the restrictions that tie Medicaid to other federal programs like SSI and AFDC. We also need federal matching funds to help cover working people with incomes too high to qualify under current Medicaid rules, but too low to purchase private health insurance without some government subsidy.

We need Congress to allow us to implement several other administrative efficiencies that will greatly enhance our ability to better serve Floridians and save both federal and state dollars. These initiatives include eliminating waiver requirements for:

- successfully tested home and community-based services for both the developmentally disabled and the elderly,
- expanding managed care programs,
- and developing a system of accountability that avoids the nitpicking that results from certain federal audit and documentation requirements.

With these government supports, and others we may yet develop, it is our sincere hope that our public/private, partnership will achieve the goal of access to care for all Floridians by the end of 1994. But we are ever mindful of the depth and complexity of the problem, and of the failure of earlier voluntary efforts to meet the challenge. For this reason, we are also moving full-speed ahead with planning and development activities to support a second phase of the Florida Health Plan. This may involve a play or pay system-- or perhaps a single-payer program. If such intervention is required, and I truly hope that it isn't, additional reforms will be ready for implementation in 1995.

Of course, to implement the play or pay mandate, we'd need amendments to the ERISA and Medicare laws. We understand that there are many groups, including labor and large corporations, who are concerned about exemptions to the ERISA preemption. Employers and labor, rightly so, want to keep the pressure on Congress to enact a national solution to our nation's health care crisis. They also want to avoid having to negotiate different insurance benefits in every state, avoid state premium taxes, and be able to trade off benefits for wages. However, to keep our promise to the people to provide universal access to health care, Florida needs to be able to regulate self-funded health insurance plans. It wouldn't serve anyone's purpose to have previously non-insuring small businesses flee to ERISA protection simply to avoid having to offer the minimum set of health care benefits. Neither would unregulated self-funded plans that offer inadequate benefits at unaffordable costs for workers achieve our goal.

Employers and labor are at great risk under the current system. Although most large employers provide comprehensive health benefits to their employees, they are also paying,

because of cost-shifting, for the employees of businesses that don't offer insurance. Companies that provide health benefits are at a competitive disadvantage to those that choose not to offer them. This bites into their bottom line, eroding their profits. Businesses and labor have a major stake in seeing that everyone pays a fair share for medical benefits. It's not only good for the people who are currently uninsured to get health coverage, but it also makes good business sense.

Although an ERISA exemption would subject employers to state regulation like other commercial insurers, the benefits to business are often overlooked. Ultimately, business will prosper when costs and risks are spread across the entire population. State reforms permitted by an ERISA exemption will lead to improved coverages; healthier, happier, and more productive workers; lower workers' compensation costs, improved competitiveness; and greater cost control.

You've probably heard about New Jersey's legal battle over a law to pay for hospital care for the uninsured by adding a surcharge to other bills. A U.S. District Court found that self-insured plans are exempt from this surcharge because of ERISA. Although Florida does not tax insurance plans to cover uncompensated care costs, any efforts to require previously non-insuring employers to offer a minimum set of benefits could be met with the same outcome if the ERISA law is not amended.

We feel there is room for compromise so that Florida has the ability to mandate certain benefits and experiment with an alternative payer system, if necessary, yet exempt in-state and multi-state employers with actuarially equivalent plans. There may be a misperception of our proposal. Businesses providing relatively comprehensive health benefits will not be hurt by our plan.

At this point I'd like to submit a copy of Florida's Flexibility Proposal and a summary of the Health Care Reform Act of 1992 for the record.

Florida has clearly not waited for a federal mandate to move ahead with health care reform. But we remain ready to work with you for change at the national level. With your help, the fourth largest state in the country is willing to try to extend the right of affordable health care to all its residents.

There is neither an easy solution, nor a single solution, and many difficult steps must be taken to recast our health care system into one that is effective, economical, and available to all. Florida has set a very ambitious goal for itself. We know that it will require hard work, some compromises, and a lot of cooperation from everyone in our state to achieve the vision of universal access to health care. We are optimists, however. We believe that Floridians want changes in health care. While we hope that we'll see a national solution soon, we can't afford to wait. We're committed to going as far and as fast as we can to see that no Floridian goes without needed health care. For some of our citizens it is a matter of quality of life. For too many, it is a matter of life and death.

Recently, it has become more apparent to me that one of the main reasons we can't seem to move on this issue is that there's a big block of people who are perfectly satisfied with the system we have now--and there's another big group that only wants reform if it's the perfect solution to all of our complex problems.

But the real path of reform is toward a good plan that may be less than perfect. We've got to get moving because even though we think we're standing still, we're really falling steadily behind.

However you proceed in your efforts, I would urge Congress to avoid a top-down approach that ignores the experience and expertise we have in state government. Under any system, states will have an important role to play in the financing and regulation of health care services. The experience we are gaining as we move ahead with our own reform efforts is a resource that you cannot afford to ignore. These reforms demonstrate our willingness to tackle the twin problems of rapidly rising costs and decreasing access to care.

To assist states in implementing their comprehensive reforms to begin correcting access and cost problems, I strongly support the Leahy/Pryor bill, which would give ten states the flexibility to develop different approaches to health care reform. Any comprehensive reform proposal passed by Congress should include a provision similar to the Leahy/Pryor bill, to allow states pursuing comprehensive approaches to continue down that path. If a consensus cannot be reached on a national reform plan this year, flexibility must be given to the states that are ready to pursue their own reforms.

Chairman Bentsen, our citizens have been waiting many years for universal access to health care. We again have an opportunity to do the right thing for our people. I support your evolutionary approach to reform and believe that by granting the states additional flexibility, we will get closer to the national reforms we all want.

PREPARED STATEMENT OF GARY J. CLAXTON

Mr. Chairman and Members of the Committee, thank you for this opportunity to discuss the pressing issue of ERISA[1] waivers for states embarked upon comprehensive health care reform.

I am here today representing the National Association of Insurance Commissioners ("NAIC"). The NAIC is a nonprofit association whose members are the insurance regulators of each state, the District of Columbia, and four U.S. Territories.

I am pleased to have the opportunity to appear today to support federal legislation that would authorize waivers of ERISA preemption for states that have demonstrated a commitment to achieve comprehensive reform in the areas of health care cost containment and access to care. We congratulate Senators Leahy and Pryor for taking a leadership role in this area by introducing S. 3180, the "State Care Act of 1992." Given the growing dominance of self-funded ERISA health plans in the marketplace, ERISA waivers are crucial for states seeking to implement reforms based upon the strengths of the current private marketplace. Employer-provided health insurance is the basis of our current private health insurance system, and for states to be able to design and implement effective strategies based on this system, states must be given the ability to pass laws and regulations that affect all private payers, including self-funded ERISA plans.

ERISA PREEMPTION

ERISA was enacted in 1974 to establish uniform federal regulation of employee pension benefit plans and employee welfare benefit plans. Section 514 of ERISA broadly preempts any state law which "relates to" certain employee benefit plans, although state laws regulating insurance and other financial services are "saved" from preemption. At the same time, ERISA prohibits states from "deeming" employee benefit plans as being engaged in the business of insurance.

The result of the ERISA preemption provision is that states generally are permitted to regulate the contracts, financial conditions, and other activities of insurance companies but are prohibited from directly regulating activities of bona fide employee welfare benefit plans covered by ERISA.[2] In practical terms, this means that when employers provide health benefits through insurance, states can regulate the terms of the insurance contract and the business practices of the insurer. When

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[1] ERISA is the Employee Retirement Income Security Act of 1974, 29 USC §1001 *et. seq.*

[2] Under ERISA, an employee benefit plan is defined as any plan, fund or program established or maintained by an employer to provide employee benefits to employees and their dependents. See 29 USC §1002(1).

employers provide health benefits through self-funding (sometimes called self-insurance), states are prohibited from regulating any part of the arrangement.[3]

WHY ERISA WAIVERS ARE NEEDED

As the critical problems associated with health care access and costs continue to grow, a number of states have begun initiatives designed to achieve comprehensive reforms that would increase the number of their residents with insurance, lower the rate of growth of health care spending, reduce administrative costs, and improve the quality of health care delivered to their residents. These states are committed to dramatic improvements in the way health care is financed and delivered. Unfortunately, as these states develop strategies to increase access and reduce cost escalation, they often find that ERISA presents a number of roadblocks to effective health care reform. As is often the case in public policy, the solutions of yesterday become the problems of today. So it is with ERISA.

The Crippling Nature of ERISA Preemption on States

ERISA roadblocks to state reform arise because of the breadth of ERISA preemption coupled with the large number of workers covered through self-funded ERISA plans.

As described above, ERISA preemption is far reaching—ERISA preempts any state law or regulation that "relates to" an employee benefit plan. The U.S. Supreme Court has noted that the preemption clause is "significant for its breadth,"[4] and has determined that ERISA preempts any state law that "has a connection with or reference to [an employee benefit] plan.[5] Thus, states generally are prohibited from: regulating whether an employer provides employee benefits and, if the employer chooses to self-fund, what those benefits might be; taxing or assessing self-funded ERISA plans; requiring self-funded ERISA plans to participate in state risk pools for uninsurables or in other risk-sharing mechanisms; or regulating any of the business practices or conduct of self-funded ERISA plans.

The significant number of working families covered by self-funded ERISA plans is growing. Self-funded ERISA plans are estimated now to cover between 50% and 60% of working Americans. Further, this portion of the private market represented by ERISA plans is the easiest part to insure. Larger employers, because of their size and relative affluence, can establish relatively stable arrangements, with low administrative costs and without significant exposure to adverse selection. Smaller employers and individuals, who are more costly to insure, cannot realistically self-fund and must purchase coverage in the commercial insurance market. However, as larger, more stable health plans leave the insured market for self-funding, the ability to achieve broad risk sharing across employers through insurance is significantly diminished. States attempting to pool health care costs more broadly find that only the riskiest and most expensive segments of the private market remain within their regulatory reach.

Example of State Reform Efforts Stymied by ERISA

The adverse effects of ERISA preemption on state efforts to improve access and reduce costs can be demonstrated easily.

One example involves funding for state risk pools. Presently, twenty-six states have established comprehensive health insurance plans, sometimes called state risk pools, to provide coverage for individuals considered medically uninsurable. Many of these states fund their risk pools through a combination of premiums from covered individuals and assessments on health insurers.[6] States choose to assess health insurers because it spreads the costs of helping uninsurable individuals back to the health insurance marketplace.

However, ERISA prevents states from levying assessments on self-funded ERISA plans to support state risk pools. This Preemption exists even though state risk pools are sometimes the only haven for uninsurable individuals when self-funded ERISA plans are terminated.[7] The result is that, in states using assessments to fund risk pool losses, the costs of subsidizing uninsurable individuals must be borne by a shrinking private insurance market while the growing self-funded market es-

[3] Under a 1982 amendment to ERISA, states are permitted to regulate multiple employer welfare arrangements, whether or not they are self-funded or ERISA plans.

[4] *FMC Corp.* v. *Holiday,* 111 S. Ct. 403, 407 (1990).

[5] *Pilot Life Ins. Co.* v. *Dedeaux,* 107 S. Ct. 1549, 1552 (1987). *See also, FMC Corn.* v. *Holiday,* 111 S. Ct. 403 (1990); *Alessi* v. *Raybestos-Manhattan, Inc.,* 101 S. Ct. 1985 (1981).

[6] In some cases, insurers can deduct part of their assessment from other state tax liabilities.

[7] We also will note that, unlike insured arrangements, there is no guaranty fund to cover unpaid claims when ERISA plans are terminated by bankrupt employers.

capes the costs altogether, even though the self-funded market contributes to the costs of the risk pools.

A second example involves recently developed strategies to pool employers in purchasing groups or cooperatives to better manage competition in the health insurance marketplace. Designs for these systems rely on large or exclusive market share, some form of community rating, and substantial employee choice among managed care alternatives. Ultimately, the strategy depends on long-term commitments from participating employers, who must sacrifice short-term savings from benefit reductions and risk selection techniques in favor of the long-term savings predicted from an organized emphasis on managed care.

ERISA poses a significant barrier to state efforts to effectively pursue this group purchasing strategy. Due to ERISA preemption, states are unable to direct self-funded employers to provide benefits through the cooperative. The potential exclusion of large, self-funded employers can seriously undermine the potential effectiveness of these purchasing arrangements. A purchasing cooperative must have substantial market share in a geographic area in order to effectively negotiate with the payers that will service the cooperative. Without the ability to assure a large market share for purchasing cooperatives, the viability of this strategy may never be determined.

Example three involves state efforts to achieve universal coverage. One option being considered by many policymakers to decrease thee number of uninsured is to require that all employers provide health insurance to their employees. A related option would be to require employers to either provide health insurance to employees or pay a tax to a public insurance program for these employees. ERISA, however, is a barrier to these employer-based approaches. Under ERISA, states cannot regulate the form, type or amount of benefits that an employer provides in a self-funded benefit plan, which effectively prevents a state from requiring an employer to provide health benefits or dictating any minimum level of benefits that must be provided. Similarly, there are many questions about whether a tax assessed on employers who do not provide a specified level of benefits would also "relate to" an employee benefit plan, because such a law would arguably dictate the employer's decision regarding the level (and perhaps type) of benefits that the employer is required to offer in the plan.[8]

Without the ability to require employers to provide health benefits or to tax employers if they do not do so, states are effectively prevented from testing the viability of this market-based approach to achieving universal access to coverage. Given Hawaii's success with this strategy (which required an ERISA waiver), Congress ought to give other states the opportunity to use this strategy to promote universal access to health care coverage.

Finally, ERISA preemption has recently been found to frustrate state efforts to more fairly distribute the burdens of uncompensated care and access for the uninsured through provider rate-setting. A federal district court recently decided that ERISA prohibited New Jersey from requiring self-funded ERISA plans to participate in the state's hospital rate-setting system, which uses DRG rates that contain surcharges for uncompensated care and other health related matters.[9] The court essentially found that a state could not require a self-funded ERISA plan to pay a state established charge that included costs other than those actually incurred by ERISA plan participants. This decision could have very far-reaching effects, because it puts in question the ability of states to fund health related programs through taxes or surcharges on health providers. Presently, over twenty states use provider rate-setting or some type of assessment on health care providers to fund uncompensated care pools and other health related programs. If the New Jersey court's decision is upheld, the health financing and delivery systems of these states could be very seriously compromised.

These examples are not intended as a complete list of ERISA roadblocks.[10] They are merely illustrative of the types of barriers ERISA erects to state reform efforts in the areas of assessments, market structure, employer requirements, and provider surcharges and taxes. Taken together, even this list presents a daunting obstacle

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[8] Several states have passed so called "play or pay" systems, including Massachusetts, Florida and Oregon. However, the play or pay component has yet to be implemented in any state, so its vulnerability to an ERISA challenge is not yet determined. It should be noted, however, that the likelihood of a prolonged ERISA challenge diminishes the attractiveness of the strategy in states.

[9] *United Wire, Metal & Machine Health and Welfare Fund,* Civ. Action No. 90–2639, D. N.J., May 27, 1992.

[10] For example, ERISA probably would preempt state efforts to establish uniform claims processing or billing procedures, uniform rules for coordination of benefits or state efforts to establish uniform data collection and quality assurance programs.

course for state policymakers in search of effective reforms. Equally daunting is the ever present concern of policymakers that any state reform action they take that somehow affects or touches upon an employer's benefit decisions could be the subject of protracted and costly litigation about ERISA preemption.

S. 3180 PROVIDES NEEDED RELIEF TO STATES

We congratulate Senators Leahy and Pryor for taking a leadership role in addressing the types of problems and uncertainties described above by introducing S. 3180, the "State Care Act of 1992." S. 3180 would permit up to ten states to seek waivers from certain federal requirements imposed under Medicare, Medicaid, and ERISA as part of their comprehensive health care reform initiatives.

For states meeting the stringent requirements in S. 3180, ERISA would no longer preempt their reform efforts in a number of important areas:

- States would be permitted to collect assessments from self-funded plans for the purposes of equalizing assessments or providing subsidies to uninsured or uninsurable persons;
- States would be permitted, with some exceptions, to establish minimum benefit packages or standard benefit packages for use by all employers, or to require that all employers provide a minimum set of benefits to their workers and their families;
- States would be permitted to develop uniform administrative procedures, electronic billing and claims processing procedures and uniform data collection mechanisms; and
- States would be permitted to establish provider rate-setting programs or to set up a system of negotiated provider rates for the state.

The limited authority granted to states under S. 3180 would address each of the problems demonstrated by the examples discussed above. Passage of S. 3180 would substantially broaden the horizons of states seeking to implement comprehensive market-based health care reforms. While we have Some concerns about the bill's limitation to ten states, we strongly believe that its adoption would encourage even greater state efforts to address the staggering problems of containing health care costs and increasing access to coverage for all our citizens.

Contrary to the assertions of some, we do not believe that S. 3180 places unreasonable or unfair burdens on self-funded ERISA plans. The bill specifically prohibits states from singling out ERISA plans for special assessments or taxes. The concept behind S. 3180 is that self-funded ERISA plans should be brought into larger reform efforts, and treated on an equal basis with other health insurance providers. In fact, implementation of S. 3180 in a state should produce positive benefits to self-funded ERISA plans by reducing their future health care costs. The bill poses strict criteria for states seeking waivers. Waivers can only be granted to states that demonstrate their intent to dramatically reduce the increase in health care spending and to dramatically increase the number of insured residents. Implementation of these reforms should significantly lower the uncompensated care burden and the annual increases in health care costs for all payers, including self-funded ERISA plans.

It is true that some of the uniformity across states that now results under ERISA will be lost. But this is a relatively minor cost compared to the significant benefits that will accrue under S. 3180 in the areas of access and cost containment. It should be noted that S. 3180 protects self-funded ERISA plans from being required to vary their benefit plans, as long as they provide a minimum level of benefits to their workers. Other areas where uniformity might be sacrificed, such as taxation and administrative procedures, will be somewhat burdensome for ERISA plans. However, it is clear that market-based reforms cannot be achieved at the state level without some accommodations from ERISA plans, and the relatively small burdens that would be imposed on these plans under this bill could not conceivably justify blocking state reforms. The overriding needs to address the plight of the uninsured and to control health spending clearly must take precedence.

CONCLUSION

ERISA is a tremendous roadblock to state health care reform efforts. Because of the breadth of ERISA's preemptive effect, and the growing market share now covered under ERISA plans, states are essentially crippled in their attempts to design reforms based on the current private market of health insurance and health care benefits. Thus far, the federal government has shown itself to be unable to fashion a comprehensive solution to our health care crisis. States have stepped in, and many states are now exploring comprehensive solutions to our problems with health care costs, access and quality. We urge Congress to provide states with the ability

to pursue these solutions by adopting S. 3180 and granting states relief from ERISA's broad preemption.

JOINT PREPARED STATEMENT OF GOVERNORS HOWARD DEAN, GEORGE S. MICKELSON, AND ROY ROMER

STATE-BASED HEALTH REFORM INITIATIVES—A FRAMEWORK

Mr. Chairman, members of the committee. We appreciate the opportunity to talk with you today, on behalf of the nation's Governors, about state-based health reform initiatives and the need for a state and federal partnership as states attempt to implement comprehensive health care reform.

No one questions anymore that America is facing a health care crisis and needs a system that makes health care affordable and available to all Americans. A comprehensive national solution must be found and found quickly. We believe that Governors must play a central role, now and in the future, in resolving the crisis and generating that national solution. We also believe, however, that in the absence of the timely enactment of comprehensive national health reform, states must be given the opportunity to work cooperatively with the federal government and the private sector to find their own solutions to the health care crisis. These state initiatives must not substitute for national reform; however, if there is no national consensus, the conclusions drawn from state initiatives will help develop one.

States have a critical interest in finding solutions to our health care crisis. States are major funders of health care for the poor and unemployed, and in many states, state government is one of the largest employers. As the chief executive officers of states, we confront this health care dilemma daily. Moreover, we face this crisis bound by the shackles of shrinking economies and balanced budget requirements. Senator Pryor has said, "The first choice for restructuring our health care system, including the first choice of almost every Governor, is that the federal government must meet the need for national comprehensive reform. However, if we cannot gain consensus on the national reforms we so desperately need, we simply cannot continue to hold states hostage to our gridlock." We agree. And we are encouraged by the strong bipartisan support of state-based initiatives, as evidenced by the impressive list of distinguished cosponsors of the Leahy/Pryor legislation.

Already, several Governors have made significant advances toward comprehensive and available health care. However, they are learning an important lesson—states cannot effect change alone. Effective health reform, even incremental state-based change, requires a relationship among states, the federal government and the private sector—a relationship that moves beyond affirmations of cooperation to strategies for change. Each member of the partnership must be willing to re-assess perspectives and take risks toward achieving lasting reform.

Can state-based health reform contribute to national solutions?

Unequivocally, the answer is yes. The expression is worn but it remains true—states are the "laboratories of democracy." States have a history of generating effective national solutions through experimentation. When he introduced the State Care Act, Senator Leahy reflected on the historical role of states in influencing social change. He noted twenty-five states had child labor statutes before Congress passed legislation in 1912, and twenty-four states had parts of the social security law enacted in state statutes before the national act was passed in 1935. This tradition continues today.

In the last several years, states have taken the public policy and political risks necessary to try new health care strategies. Most notably, states have led the way in strategies to address infant mortality—strategies that have contributed to a reduction in the infant mortality rate across the nation. States can be trusted, and have a track record to prove it.

We believe that there is a growing consensus about the importance of state experimentation in forming a national reform strategy. Just recently, C. Everett Koop, former surgeon general of the United States, in a guest editorial in The Washington Post, added his voice to the chorus of those encouraging state experimentation in the development of national health reform.

State-based comprehensive reform has its detractors. It has been argued that such an approach will delay or ultimately defeat the chances of national health reform. Moreover, there are some who believe that in the absence of a national solution nothing should be done. State experimentation must be permitted to contribute to the debate. We cannot and should not tolerate a one-dimensional logic that requires a national solution or none at all. Health reform is too important and too complex, and Americans deserve better.

We believe that state experimentation will lead to more meaningful and enduring national health policy. Most states, like the nation as a whole, have urban and rural regions and socio-economic diversity throughout those regions. They are perfect laboratories to test the efficacy of different approaches to reform. But states cannot implement these reforms alone. Meaningful health reform, even at the state level, can occur only when we re-assess the complex interrelationships between payors and providers of health care and restructure the maze of state and federal regulations that supports the current system. States are capable and willing to make such changes.

However, to successfully implement state-based health initiatives, states need changes in federal statutes and regulations that will allow certain strategies to be tested—a view recently. supported in a June 1992 report from the General Accounting Office.

What state and regulatory changes do states need?

(1) The existing waiver, process under be Social Security Act must to be streamlined. The existing waiver authority for experimentation is so burdened by administrative complexity that it effectively eliminates the possibility for change.

(2) Waiver authority under the Social Security Act must be expanded to permit greater experimentation with Medicaid and Medicare. The current Medicaid and Medicare system does not allow states sufficient flexibility for experimentation. States should be permitted to test different delivery systems to provide Medicaid services to Medicaid clients.

(3) Waiver authority is needed under federal programs that currently do not provide such authority—the Employee Retirement Income Security Act (ERISA), tax code, anti-trust statutes. Several important access and cost containment strategies cannot be implemented as a part of state experiments without federal statutory changes.

ERISA. Self-insured health plans that meet the qualifications defined in the ERISA statute are exempt from state laws. Except for specific statutory exemptions for certain aspects of Hawaii's health care program, no vehicle exists for states to receive an exemption or waiver of the ERISA preemption for self-insured plans.

States are interested in testing new strategies that would include:

- levying assessments to create statewide pooling arrangements;
- requiring employers to either offer a standard benefits package as defined by the state or pay into a public program;
- developing common administrative procedures that might include uniform claims forms and billing procedures; and
- establishing uniform provider reimbursement rates.

None of these strategies would be possible without a waiver of the ERISA preemption for self-insured plans.

Anti-trust. States that are considering the development of a statewide, negotiated, rate-setting system would need protection for themselves and their providers from anti-trust legislation. Similarly, protection from anti-trust legislation is necessary to develop a single claim form for use by all insurers in the state.

How can be federal government facilitate and oversee state reform initiative?

Even if Congress and the administration make all of the statutory and regulatory modifications to existing waiver authority that the states would like, and even if they establish waiver authority in statutes where none currently exists, implementing state-based reform initiatives still would be next to impossible. The federal government must establish a process to facilitate development and implementation of state initiatives. That process must have three characteristics.

- There must be a person or an entity with the authority to grant *all* waivers necessary to move forward with a health care reform plan;
- there must be a timely approval process; and
- it must be possible for states to receive advice and conditional approval of initiatives as they are developed at the state level.

What is the states' commitment to this partnership?

What do states bring to the table as part of the partnership? At a minimum, states could be expected to ensure that a viable reform initiative is proposed for consideration by federal authorities. All initiatives for state health reform would be supported by the state legislature and Governor. This would ensure that all relevant stakeholders have participated in the proposal's design. Moreover, states will ensure that Medicare services will continue to be provided to the Medicare population, and that federally mandated Medicaid services will continue to be provided to federally

mandated Medicaid recipients. Finally, we are committed to a fair and impartial evaluation of state initiatives. Only with such public and impartial scrutiny can these initiatives be seen as models for national reform.

What about financing?

The Governors believe that a viable financing strategy is an essential component of any initiative. Both the federal and state governments as well as the private sector have a strong interest in controlling costs in the health care system. However, expanding access to care will cost money, and the annual cost-neutrality precepts developed for waivers under the Social Security Act must be reconsidered in light of the breadth and scope of proposals that would be considered under this partnership model. States will propose broad-based restructuring of health care systems. To do so they must expand access and control costs. Therefore, the following principles should guide concerns about the costs of reform initiatives:

- The federal and state governments must be willing to share both the financial risk and the ultimate cost savings.
- Reform initiatives should not be expected to be budget-neutral on an annual basis. Although cost-neutrality of health initiatives would be ideal for both states and the federal government, it should not be the sole determining factor in the approval of state waiver requests. However, initiatives can be expected to be cost-effective and efficient over the life of the project.
- The states will assume responsibility for their share of the increased costs of expanded access. The federal government should do the same. In addition, the federal government should provide some resources to help states develop their initiatives.
- The states will work with the federal government to develop a "stop-loss" proposal to limit federal liability for potential project cost overruns.

S. 3180—THE STATE CARE ACT OF 1992

Having outlined our perspectives on a framework for a state-federal partnership to support comprehensive state-based health reform, we would like to take a moment to discuss S. 3180, the State Care Act of 1992, introduced by Senators Leahy and Pryor and endorsed by the National Governors' Association.

We believe that this legislation has captured the essence of a state-federal partnership—state flexibility, accountability, and a vision of comprehensive health care. This legislation establishes additional waiver authority under Medicaid and Medicare and establishes the authority to test strategies that are currently precluded under ERISA. We look forward to the opportunity to consider other areas for waiver authority as states develop their strategies to move forward.

Medicare and Medicaid Waivers. We believe that the Medicaid and Medicare waiver provisions of S. 3180 are consistent with our vision of a state/federal partnership. As it is currently drafted, the legislation gives states the ability to include Medicare in all-payor negotiated rate systems for hospitals. We would like that authority to include other Medicare providers so that states could develop more uniform negotiating strategies and establish more equitable cost containment and administrative systems.

Regarding Medicaid, we believe that the legislation explicitly reaffirms the states' commitment to maintain strong quality assurance and quality control systems that are currently within the program. States understand that under the current fragmented health care system, the Medicaid program is the only safety net for some of our most vulnerable populations—poor pregnant women and children. Medicaid waivers will not erode that safety net. Under this legislation, states will conduct fundamental comprehensive reform that includes increased access to care. They must be able to restructure their health care finance and service delivery systems, including Medicaid beneficiaries and Medicaid payment systems, so that quality and affordable health care are available to all the citizens of the state.

ERISA. It should be no surprise to anyone that the ERISA provisions of this legislation are controversial. No wonder, more than sixty percent of all health coverage in the nation is provided through self-insured plans—plans that are exempt from state regulation. We believe that the ERISA provisions in S. 3180 have been well constructed and narrowly crafted to recognize the concerns of the business and labor communities. For example, the exemption to the ERISA preemption applies only to health benefits and not to pension and non-health welfare benefits. Also, the legislation establishes criteria by which self-insured plans are exempt from a minimum benefits package if a plan meets minimum employee dollar equivalents. It is our understanding that the dollar value is extremely favorable to the business community

and should not affect the ability of multi-state employers to offer uniform health benefits to all its employees.

The ERISA provisions are also controversial because they permit states to collect assessments from benefit plans that would otherwise have been exempt under ERISA. The limitation of this provision must be recognized. First, a state can apply the provision only if its plan is approved under this demonstration, and only if that assessment is approved by the legislature and signed by the Governor as part of a comprehensive health reform strategy. The provision as written does not guarantee an assessment, it gives the state an option for a financing mechanism. That, we argue, is a reasonable concession to states who will agreed to meet five-year federal cost neutrality provisions, statewide annual cost-containment targets, and fairly stringent access requirements.

The ERISA provisions are fundamental to the entire state/federal partnership. Consider the following. Without the ERISA provisions:

- states could establish a minimum benefits package—but sixty percent of all of those currently with health coverage would be excluded from having that minimum package available to them;
- states could develop common administrative procedures—but claims of sixty percent of those currently covered would be excluded from the unified administrative structure; and
- states could establish a negotiated rate system—but sixty percent of claims would be eliminated from the negotiated rates.

In short, without the ERISA provisions the expectation of testing national reform models and establishing a statewide cost containment strategy is little more than a cruel hoax.

Anti-Trust. S. 3180 contains no provisions for protection from federal anti-trust action. As the legislation was being developed, it had been thought that there would be no need for such protections because of the "doctrine of state action." However, a recent Supreme Court decision, *FTC* v. *Ticor,* suggests that the doctrine of state action is insufficient protection for states and providers who might engage in actions thought to violate anti-trust statutes. We request that such protections could be included.

Waiver Process. The legislation removes an important roadblock to the implementation of state-based initiatives by creating a commission to facilitate the waiver process. Consistent with our vision of a state/federal partnership, the legislation establishes a commission that has the authority to give states a single place to secure waivers and receive technical assistance in the development of their demonstrations. This is significant.

Governors do, however, have some concerns about some of the provisions of S. 3180. The statute permits only ten states to establish demonstrations. This may be too few. In discussions with other Governors, there is some concern that others will be ready to participate under the legislation in the near future and no slots will be available. We urge you to expand the number of demonstrations beyond ten.

Cost Neutrality. Governors are most concerned about the cost-neutrality provisions. Permitting states to be cost-neutral over the five-year period rather than annually is an important step. Also important are the instructions to the commission to make recommendations to Congress about the advisability of increasing federal assistance as well as make recommendations about the amount and source of those funds for comprehensive state-based initiatives. However, they may not go far enough. Some Governors think that the access and cost containment requirements of the legislation when coupled with five year federal cost neutrality is a recipe for failure. They may be correct. We hope not. We encourage you to consider other alternatives that might be helpful to states as they proceed down the path of reform.

Finally, over a period of several months Senator Leahy's and Senator Pryor's staffs, NGA, and representatives of the business and advocacy communities have worked hard to craft this legislation. We now have a careful balance between state flexibility and accountability. We believe that you will be encouraged to diminish state flexibility and increase state accountability. If states are to experiment, that carefully crafted balance now established in the legislation must not be eroded.

CONCLUSION

Mr. Chairman, we have described a framework by which states and the federal government can work together to address one of the most important problems facing our nation today. As you heard in testimony before you today, the nation's Governors are taking the necessary political and public policy risks that leaders must take to effect meaningful change in this nation. Moreover, some of us are taking

those risks now. We hope that you will join us in this partnership—a partnership that will contribute to changing our nation's health care system.

You have before you legislation that will help states. It is not perfect, but compromise never is. By helping states you will have taken a step toward the goal of making quality health care affordable and available to all.

RESPONSE OF GOVERNOR GEORGE MICKELSON OF SOUTH DAKOTA TO QUESTIONS SUBMITTED BY SENATOR PRYOR

Question No. 1. I would like some real, live examples of frustrations that you as governors, you as the people under your health care umbrella, your deliver system, out in your four respective States, are faced with on a daily basis in dealing with the federal regulations that we set up here in dealing with some of the areas of regulations that have really caused you some pain, and, in fact, may have ultimately caused you to deliver fewer services to the people that you represent. So, that will be under the area of daily frustration.

Answer. Frustrations:

- *Insurance*—ERISA exemptions create an inability to assist South Dakotans with serious health "insurance" problems. The state currently assists approximately 1,000 people per year with their insurance problems. However, those people who have claim problems or lack of coverage problems with a self-insured plan are exempt from state regulations so the state can't help them rectify their problems. Furthermore, ERISA has given self-insured Multiple Employer Welfare Arrangement (MEWA) an argument regarding jurisdiction which further tie up the state's resources in taking legal action against them.
- *Department of Social Services*—One of the biggest problems for Medicaid in recent years is the fact that the state has been forced to operate without new regulations, but rather must develop policy based upon analysis of the law itself. This is true for OBRA '87, OBRA '89, and OBRA '90. An example of this is the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program where HCFA has not promulgated regulations but is instead using the Medicaid Manual and Regional Identical letters to impose burdensome program requirements. Specific requirements include: (1) screening 80 percent of children by 1995, (2) defining and reimbursing partial screenings, and (3) screening for lead poisoning. The EPSDT requirements contradict the Medicaid principle of medical necessity and are also discriminatory since not all Medicaid eligibles may receive services under EPSDT. Another example is the requirement to submit annual state plan amendments documenting pediatric and OB/GYN provider participation rates. The Medicaid Manual material which is used by HCFA in lieu of regulations far exceeds the requirements in the lain. Finally, an area of great attention recently is the Boren amendment. This amendment allows hospitals to sue the state Medicaid programs for "reasonable" payments. While this refers to federal law and not regulations, regulations could provide states some shelter from Boren-type lawsuits. HCFA says this is an area where states need to be free to develop their own programs but this issue has been greatly confused by the courts, interpreting what is a vague and poor statute.

  HCFA has tried to finalize regulations regarding provider specific taxes and provider donations. Although some compromise has been worked out, there is plenty of room for concern among the states with NGFA's charge to develop new rules defining "broad based," "hold harmless," and "positively correlated." The agreement (P.L. 102–234) and the possibility of new rules were only supported because the October 7, 1992 alternative rules were even more limiting of a state's ability to generate match revenue. Many states think NGFA is being far too controlling of a state's ability to raise general funds for Medicaid match.

  Finally, the Clinical Laboratory Improvement Act (CLIA) is an example of federal regulations which will increase the paperwork burden and cost of state agencies and providers in the Medicaid program. The requirement to certify laboratories and the procedures they can perform are new and states are required to comply within very short timeframes with minimal and inconsistent federal guidance. In addition, there are stringent claims submission and processing requirements which will impede the state's ability to promptly pay claims for laboratory services.
- *Department of Human Services*—A large percentage of the Department of Human Services' clients receive services through the Medicaid program or other federal funding sources (i.e., block grants for mental health and alcohol and drug abuse). Without this federal support, South Dakota probably would not be able to offer the current level of services. Rules and regulations are needed to ensure that health and safety concerns are met and that services are appro-

priate for the individual. While there is always room for improvement, the department is comfortable with the majority of the requirements. There are, however, a few issues which need to be addressed.

The Division of Developmental Disabilities manages a Home and Community-Based Services Waiver. Under the waiver, habilitation is provided. Habilitation services may include pre-vocational training, supported employment, and education. For a client to receive these three services under habilitation, they must have been institutionalized at some time. This is a problem because not all clients provided services under the waiver have been institutionalized. One of the purposes of the waiver is to avoid institutionalization. Therefore, it is illogical to not allow these individuals to benefit from these services.

Medicaid waivers require an initial application and subsequent reapplications, at either three-year or five-year intervals. The department does not feel that reapplying should be necessary because states are required to report annually and the federal government is required to monitor each waiver. The federal government has the authority to terminate a waiver for non-compliance. Also, because services under a waiver are not as secure as services in the state Medicaid plan, states are subject to control and manipulation that may exceed legislative intent. We feel that Home and Community Based Services should be a part of the state Medicaid plan as a state option and not subject to the reapplication process.

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) made significant changes in nursing home service delivery. One of the requirements of OBRA '87 is that states conduct Preadmission Screening and Annual Resident Review (PASARR). The intent of PASARR is to stop states from warehousing individuals with mental disabilities in nursing homes. South Dakota does not warehouse individuals. There are very few nursing home residents that could be considered inappropriately placed. This state has been doing an excellent job at the front end, that is, channeling individuals to appropriate services. Under South Dakota law, anyone applying for admission to a nursing home must be screened to ensure that this level of service is needed and appropriate. While states are required to carry out PASARR activities, the Department of Health and Human Services has failed to provide rule/regulations as required under OBRA '87. The department feels that the PASARR requirement should be repealed.

Medicaid requires that mental health services provided in a clinic setting be directed by a physician. We do not feel that this is absolutely necessary. Physician directed services are not required under our administrative rule. This requirement adds costs and administrative burdens without necessarily improving quality of services.

This year's reauthorization for block grant funds removed the Governor's discretion to use 10 percent of the funds for either area of service. In past years, this 10 percent was used for mental health services and was also incorporated into this year's budget. This change occurred at the "eleventh hour" which has led to service delivery problems. Basically, the department will have to cut mental health services.

Question No. 2. I would also like to ask each of you in your States to try to give us a ballpark figure. We are talking about paper shufflers here. How many people, what resources, what manpower, or people power are employed on a daily basis just in keeping up with the federal regulations that the States have to deal with?

Answer. Resources required:

- *Insurance*—Approximately 5 FTEs are employed for federal regulations purposes. This Division of Insurance does not get as much federal funding or administer as many federal programs as other agencies in the state.
- *Department of Social Services*—It is difficult to estimate the resource used to keep current or changing federal regulations regarding Medicaid.
- *Department of Human Services*—Reporting requirements under the block grant are excessive. Just for mental health, an estimated 1 FTE is used to just fulfill reporting requirements. Part of the problem stems from a lack of consistent federal policy.

Responses of Governor Roy Romer of Colorado to Questions Submitted by Senator Pryor

Question No. 1. I would like some real, live examples of frustrations that you as governors, you as the people under your health care umbrella, your deliver system, out in your four respective States, are faced with on a daily basis in dealing with the federal regulations that we set up here in dealing with some of the areas of reg-

ulations that have really caused you some pain, and, in fact, may have ultimately caused you to deliver fewer services to the people that you represent. So, that will be under the area of daily frustration.

Answer. Frustrations:

Dealing with federal regulations can be extremely frustrating. However, even more frustrating is operating under circumstances where law has been established by Congress and no regulations have been drafted. For example, the lain was changed in the late 1980s concerning the federal requirements for utilization review in Medicaid programs. However, the most recent rules published by the federal government (1991) carry the requirements that were in place under the old law. This is very confusing, as well as counterproductive as staff work to comply with rules that are no longer relevant.

Another example is the recent enactment by Congress of limitations upon provider-based taxes. The administration promised the rapid development of regulations (the last date given by them for distribution was August 31, 1992), and to date, no regulations have been distributed.

These examples are characteristic of how HCFA sometimes takes years to adopt rules in response to Congressional action—leaving states to guess at the nuances to be developed by HCFA and retroactively applied.

Question No. 2. I would also like to ask each of you in your States to try to give us a ballpark figure. We are talking about paper shufflers here. How many people, what resources, what manpower, or people power are employed on a daily basis just in keeping up with the federal regulations that the States have to deal with?

Answer. Manpower Costs:

It is very difficult to quantify exactly how many person-hours are consumed in dealing with federal regulations, their interpretation, complying with requirements, undergoing countless audits and inspections, etc. It is safe to say that a significant amount of our time is lost to this process, as well as the process of defending against negative federal audit findings and other adversarial encounters.

There must be a better way to handle this joint federal-state partnership. Rather than hiring staff at both the federal and state level to deal with the complexities, lets figure out how to do business so our time and the taxpayer's money can be spent taking care of people.

Response of Governor Howard Dean of Vermont to a Question Submitted by Senator Pryor

Question. I would like some real, live examples of frustrations that you as governors, you as the people under your health care umbrella, your deliver system, out in your four respective States, are faced with on a daily basis in dealing with the federal regulations that we set up here in dealing with some of the areas of regulations that have really caused you some pain, and, in fact, may have ultimately caused you to deliver fewer services to the people that you represent. So, that will be under the area of daily frustration.

Answer. Frustrations:

Incorporating Medicare into the state's universal access provisions would entail obtaining permission to manage Medicare at the state level to one degree or another. Such waivers are not lightly given, and are usually issued within strict limits, if at all. Expanding the scope of benefits or altering the method of delivery do not seem likely candidates for waivers as things now stand.

Medicaid has already been twisted and tortured every which way. Waivers might be sought if we decide to roll Medicaid into the larger universal access program. Oregon's recent experience with this is not encouraging.

The real issue for us may be ERISA. Either of our universal access plans—the single payer or the multiple regulated payer—could require ERISA waivers to implement. In general, ERISA was meant to protect employee benefits, not provide a safe-haven from state regulation of health insurance plans. In order to implement universal access plans, we will most likely need to regulate all group health plans, not just a portion of them.

The Vermont statute requires a common benefits package. This should apply across the board, not just to those plans insured through insurance companies. Although larger self-insured employee welfare benefits plans are likely to be comprehensive in coverage, it presents a distinct loose end for us to deal with. Smaller employers may band together to provide group plans also, and this raises the "MEWA" problem.

There may be a question whether employers with employee welfare benefit plans can be taxed in order to generate funds to pay for coverage of the uninsured. If this is the case, most of the "pay or play" schemes would be moot. Only the "insurance"

plans could be taxed. This would present an incentive to drive more employers to self insure.

PREPARED STATEMENT OF SENATOR DAVE DURENBERGER

The issue before us today is what public policy change is most effective in moving us to universal coverage of the financial risk of all Americans for medical expenses; and (1) what role private employment—the workplace—can play in reducing the growth in cost of that coverage; and (2) what role the states can play in increasing access to uninsured individuals.

In 1991, employers—public and private—paid over $174 billion for employee and family health expense protection for a total of 139 million Americans. We should continue to encourage employer coverage.

Up to now national and state policy of "free health insurance" in the workplace subsidized by billions of dollars in tax subsidies encourages the cost escalation problem we face in medicine today. Until just recently most employers provided the health insurance for free—employees paid no taxes on the employee contribution as they would on wages. This kind of coverage enabled doctors and hospitals to shift the costs of the uninsured or the underinsured to employer paid insurance.

Increasingly, employers across American are individually and in coalitions taking steps to change this system and to reduce the negative impacts employers have on medical costs. Recently, major new efforts are being undertaken by employer coalitions in my state of Minnesota, in Florida, Colorado, Ohio and elsewhere. To use the power of employee and family coverage to change the behavior of doctors and hospitals and also to change employee behavior in the way they use the system. This will have a positive impact on cost containment.

State government has also and unnecessarily increased the cost of employer-provided health insurance with some 800 provider coverage mandates imposed on all health insurance sold in their states. Only in the last year or so have they slowed this effort. The only protection employers have had against this added burden imposed by state government has been ERISA.

Many employers operate in many states. They have an interest in uniformity. So they have an interest in not being treated as insurance companies and regulated as such. ERISA prohibits the states from individual administrative and provider coverage requirements. This can reduce extraneous costs and encourages cost containment actions by employers and employees.

In the absence of federal action to move us to universal coverage of the financial risk of medical health and medical expenses, we in this Congress have an interest in two things:

First, we have an interest in encouraging states to act to increase access by reducing the cost of coverage to groups of people. So we want to encourage small group insurance reform, medically uninsurable risk pools, elimination of anti-managed care provisions and legislated mandated benefits, and malpractice reform. We want to reduce the inequities of experience rating and of cost shifting and we want to encourage equity pricing between employers.

Second, we have an interest in encouraging employer cost containment activities. Because employer plans are the largest part of many medical markets, especially in high-cost urban areas, we must encourage employer cost containment programs. This is particularly true of those that work to change provider and consumer behavior because they not only improve and expand quality and access, they reduce the cost for all users in the community.

The problem with the current ERISA preemption as exacerbated by recent court decisions, is that the burden for state efforts to contain cost and expand coverage falls disproportionately on smaller employers and Individuals who cannot afford to self-insure and get ERISA protection. The effect is to discourage employers and small groups from providing coverage. 51% of the 35 million uninsured are employed; millions more of the uninsured are dependents of employed individuals. We must *support,* not discourage employer coverage.

The problem for the self-insured in accepting the state access programs we will hear about this morning is that they face the prospect of having their own and their employee's efforts at cost containment discouraged by the added costs of state rules and regulations on how to do cost containment; or they face the burden of 50 different administrative procedures and 50 different guarantee funds in 50 different states; or they face the prospect of the federal and state governments doing together to employer group health insurance what they are doing in the environmental compliance area.

It is quite likely that the federal government will move to qualify health benefit plans even beyond what we are doing to define basic benefit prescriptions in small group insurance reform. In light of court decisions and some abuse we should do so with regard to the self-insured.

We in the Congress may likely do this. We are more likely to do this than to take financial to universal coverage. At least in the near future.

So in recognizing the reality of what the states are doing and are trying to do, I have drafted an ERISA waiver bill that I plan to introduce tomorrow. Senators Jeffords and Chafee have agreed to co-sponsor and I encourage others on this committee to join me.

I commend my colleagues Senators Leahy and Pryor for their commitment to addressing the problems of federal waivers. My proposal is broader than their bill, S. 3180, in that it would be available to all states, not just 10 demonstration states. But it is a narrower step into ERISA, because it affects only the FINANCING mechanisms available to state. It does not allow states to impose substantive requirements on self-insured employer benefit packages nor how self-insureds manage their plans.

Nor does this bill intrude into the states' access plans. To obtain an ERISA waiver, the state must apply to the Department of Labor which can seek the input of HHS. But the review by the federal government is on the financial equity of the state scheme, not its substance. It is ironic that an effort to increase state creativity and flexibility through waiver reforms might simply impose new federal requirements on the states. Is this simply MORE and different federal mandates?

Mr. Chairman, let me close by saying that I commend the states, including the State of Minnesota, that are trying to undertake health reforms. I don't think we should stand in their way. I also commend many creative self-insured companies that are providing leadership in the area of managed care, cost containment, and quality improvement.

I hope we can devise an accommodation between these groups, and hope my legislative effort creates that middle ground.

Prepared Statement of Senator Charles E. Grassley

Thank you, Mr. Chairman. I agree with those who argue that we need to develop a health care reform framework at the national level if we are to truly reform the system.

Unfortunately, I am having a hard time discerning the progress toward that end that some detect in our debates on this matter. Certainly we are dealing with an extremely complicated problem, from a technical point of view, from a policy point of view, and from a political point of view. And this complexity gets in the way of developing quick consensus.

Nevertheless, whatever the reason, in my view we are log-jammed here at the Federal level on the matter of comprehensive health care system reform.

Therefore some of the states are acting. And, as long as we are log-jammed at the Federal level, and State action holds out the promise of bringing relief to some of our citizens and dealing with some of the problems everyone agrees are there, then who can fault the States from doing what they can in the way of health care reform?

So I think that this hearing on some of the obstacles Federal law and regulation might put in the way of State action is a timely one. And I hope that our witnesses will help clarify the pros and cons of various steps being urged on the Congress to facilitate State action.

Prepared Statement of Karen Ignagni

The AFL–CIO appreciates the opportunity to share with the Committee its views on S. 3180, the State Care Act of 1992. We commend the sponsors of this legislation for their commitment to the goals, which we share, of expanding access to health care services and bringing health care inflation under control.

This testimony addresses the fundamental question that underlies this legislation: Should Congress give states waivers to develop their own programs while the debate about health care reform strategies continues at the national level. The members of this Committee and the entire Congress are being called upon to make key decisions about the direction and shape of health care reform. As you fashion the appropriate blend of federal and state responsibilities, there are some key issues that merit discussion:

1. Would state demonstration programs postpone enactment of a national health care reform plan until the results of the demonstrations are known? If so, can we afford to wait?
2. Given that many states are facing severe fiscal crises, can they be expected to move forward on health care reform without additional federal financial support?
3. If the Congress chooses to develop health care reform solutions at the state level will the result be a patchwork quilt of coverage, eligibility and performance across states?
4. Based on the health care bills that already have been passed in states, can it be concluded that state legislatures are in a better position than Congress to balance varied constituent Interests and design fair and equitable health system reform plans?

As you consider these questions, we urge you to evaluate the performance of current state-based programs, from Workers' Compensation to Medicaid, to separate the promise of state health care reform legislation from its reality and to weigh whether the goals of S. 3180 can be achieved at the state level.

The men and women of the AFL–CIO have long believed that the most efficient and effective approach to the health care crisis involves a national solution, as opposed to 50 state plans. We believe that an opportunity for consensus on this issue is fast approaching and that the key goals embodied in this proposed legislation can be achieved nationally. Nonetheless, in the context of a broad national program, we support giving implementation flexibility to the states.

During consideration of the Employee Retirement Income Security Act (ERISA), the AFL–CIO strongly supported the principle that states should not regulate employee welfare plans. In the words of Senator Javits upon passage of ERISA in 1974:

> "Although the desirability of further regulation—at either the state or federal level—undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive federal interest and the interests of uniformity with respect to interstate plans required . . . the displacement of state action in the field of private employee benefit programs."

Given the significant time, effort and resources that would have been devoted to complying with various state laws, union members supported the enactment of a uniform federal health care program. Now, almost 20 years later as we evaluate the rationale for this position, we have concluded that the concerns articulated in the 1970s are even more relevant today. They are: the need for federal action, the precarious financial condition of states and the uneven performance of a variety of existing state-administered programs. In addition, in reviewing the state health plans that already have been passed, we are concerned that the goals set out in S. 3180 will not be met.

URGENT NEED FOR FEDERAL ACTION

Nearly a third of Americans have no health insurance or are under-insured. The vast majority of them are people who work hard, who do their level-best to provide for their families, and yet they are only an illness or injury away from financial ruin. What we need is fundamental change of the health care system. That change should be based on the premise that all Americans should have access to basic medical services at a price they can afford.

From labor's perspective, we've seen the issue of health care nearly consume the collective bargaining process in this country. In every industry, employers have moved to cut back on health benefits or have demanded that union members sacrifice wages and other benefits in order to keep their health care.

For more than half of union members who are forced to strike, health care is the number one issue in dispute. As it stands, the free market rewards employers who deny health benefits to their employees. This has created a cross-subsidization in health care that drives costs up even further. We have learned through several years of painful experience that, absent government action, there will be no end to this cycle.

In theory the State Care Act would address this urgent need by giving increased flexibility to states so that they could design their own programs while debate continues at the national level. In practice, however, the Act could well postpone national reform for several years while the state demonstrations are evaluated.

INCREASED FINANCIAL PRESSURE ON STATES

Many states are currently facing severe fiscal constraints that would limit their ability to initiate comprehensive health care reform. Many of these problems can be traced to the poor condition of the economy over the past two years. With actual

revenue falling far below projections, many states have had to endure multiple rounds of budget cuts and tax hikes as they struggle to balance their budgets. The National Association of State Budget Officers (NASBO) recently reported that 29 states were forced to reduce their enacted FY 1991 budgets by more than $7.5 billion to remain in balance. For FY 1992, the states have collectively raised taxes by more than $15 billion, following on the heels of a $10 billion increase in FY 1991. On average, state budgets proposed this year contain growth of just 4.8 percent. According to NASBO, this is "the lowest rate of growth since 1983 and represents a reduction of services in many states."[1]

Even without the recession, many states would be facing a number of constraints on their ability to initiate costly new programs. In the early 1980s, the Reagan Administration eliminated a number of federal programs that provided financial assistance to state and local governments. These programs had provided states with over $40 billion of revenue between 1979 and 1981.

A related problem over the past few years has been the underfunding of many key block grant programs. While there has been substantial growth in block grants for anti-drug abuse programs, other grants for preventative health, social services, and community services have not kept pace with inflation, while those for job training, low income home energy assistance, and education have been cut. States have been forced to use an increasing share of their revenue to make up for lost federal dollars.

Given this situation, it seems unlikely that many states will be able to organize the kind of large scale experiments in health care financing and delivery that are envisioned in the State Care Act. Even if states manage to establish such programs, it seems probable that they will be subject to the same kind of budgetary pressures that are forcing large cuts in state services across the country. This may be one of the central lessons from the Massachusetts experience, where a promising attempt to use employer mandates to provide health insurance to all the state's citizens has been dramatically scaled back due to the budgetary and economic pressures generated by the prolonged economic downturn.

TRACK RECORD OF STATE PROGRAMS MEETING FEDERAL GUIDELINES

Even during periods of economic expansion, the track record of state programs in meeting guidelines established by the federal government is not encouraging. In examining the history of such programs as Occupational Safety and Health, Workers' Compensation, and Medicaid, there is a common thread of states falling short of fulfilling their responsibilities. It is often difficult to determine whether responsibility for this lies with the states, the federal government, or somewhere in-between. Nonetheless, the fact that reality falls far short of past promises should cause us to be much more cautious about claims that states should take the lead in health care reform.

A. Occupational Safety and Health

In 1970, the Occupational Safety and Health Act established federal workplace safety and health regulations. States were permitted to develop their own programs, provided that they met federal standards. To date, only 21 states operate approved occupational safety and health programs and unsafe working conditions continue to exact an enormous toll. More than 10,000 workers are killed every year, one worker every hour of every day, more than six million workers are injured on the job and sixty thousand are permanently disabled. While states that operate their own safety and health programs tend to conduct more inspections than the federal agency, state inspections tend to be less comprehensive with fewer serious citations issued and significantly lower penalties imposed.

Outraged by the catastrophe in Hamlet, North Carolina, in which a workplace fire unnecessarily claimed the lives of 25 poultry workers, the AFL–CIO called upon federal OSHA to withdraw approval of the North Carolina state plan. Federal OSHA did initiate withdrawal proceedings, but suspended this action, even though North Carolina has yet to correct all the deficiencies in its plan. After the Hamlet fire, federal OSHA also conducted an evaluation of the other 20 state OSHA programs, which centered on the states' ability to operate effectively in 36 performance areas. All of the state plans were found deficient in bringing performance to a level at least as effective as that of federal OSHA.

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[1] *Fiscal Survey of States,* National Association of State Budget Officers, National Governors Association (Washington, D.C., April 1991).

B. Workers' Compensation

In 1970, as part of the Occupational Safety and Health Act, Congress authorized and the President appointed a national commission to evaluate state workers' compensation programs. In 1972, the national commission issued its report and made 84 recommendations, including 19 criteria considered to be essential to the survival of the state system. The commission suggested mandating federal standards to ensure adequate, prompt, and equitable protection if the 19 recommendations were not incorporated into state programs by 1975. Now, 17 years later many states still do not meet the Commission's criteria in the areas of coverage for occupational diseases, benefit levels, and rehabilitation services. So far, the average compliance rate is only 66 percent. Since 1980, progress toward meeting the criteria has virtually ceased. Three states do not have mandatory workers' compensation coverage. Of those that do, many do not cover certain types of employees, such as domestic workers, farm workers, and employees of small businesses. Some states waive responsibility for certain employers, such as realtors and taxi cab owners, and a significant number of states limit either the duration or the amount of benefits for different types of disability.

The decision to leave workers' compensation in the hands of states was contingent on compliance with the national commission's findings. Since that time, some states have made strides in improving their programs; however, the overall condition of the workplace has worsened. A recent Bureau of Labor Statistics survey indicates that the incident rate for occupational injury and illness has grown from 7.9 per hundred full-time workers in 1986 to 8.8 per hundred in 1990. Lack of compliance with the national Commission's recommendations has left workers and their employers struggling to improve the various state programs to insure that adequate and fair protection from work-related injury will be implemented.

C. Medicaid

As the Committee evaluates S. 3180, we believe that it will find the Medicaid experience a compelling argument for not moving ahead in this direction. Indeed over the past few years, many of the initiatives of this Committee have been directed toward establishing uniform program standards across states.

While the legislation when enacted contained sweeping promises about establishing a health care safety net for the poor, the reality of the program has been a jumble of eligibility, reimbursement and benefit policies across states. In California, a family with an income below 79 percent of the federal poverty level qualifies for coverage. The average for all states is 47 percent, and in Alabama eligibility is set at 13 percent of poverty.

This experience raises substantial questions in our minds about states' financial ability to assume broader responsibilities without the benefit of federal resources.

ERISA: IMPEDIMENT TO REFORM OR PROTECTION AGAINST INEQUITABLE STATE FINANCING PROPOSALS?

The AFL–CIO is concerned that the State Care Act would allow states to obtain waivers from the Employee Retirement Income Security Act (ERISA) for the purposes of regulating and taxing existing employee welfare plans. It is our belief that states will use these waivers to levy extremely regressive taxes to finance their health care reform plans. Recent evidence suggests that the costs of state health care reform will be disproportionately borne by union workers and their employers.

ERISA, which was enacted in 1974, provides a single set of federal standards for the regulation of pension plans. The legislative history indicates that it was the intention of the original sponsors of the legislation that Congress would also develop a set of federal standards for the regulation of health and welfare plans, to avoid passage of 50 state laws. Congress preempted states from regulating welfare benefit plans. The only exception was a waiver granted to Hawaii to preserve its comprehensive health care system that mandates that all employers provide health care protection. Despite pressure from trade unionists, no further progress has been made toward national health care reform. In the meantime, several states have sought waivers from ERISA allowing them to regulate health plans.

Through our state bodies, trade unionists have been working in a variety of coalitions to advocate policies that are consistent with our pursuit of national reform. At the state level, unions have advocated cost containment legislation designed to stem the tide of health care inflation. We also have advocated universal access proposals that depend on broad-based and equitable financing imposing requirements on all employers to contribute to the cost of health care services.

To date, state legislation has fallen far short of these goals. Moreover, not one of the state bills that already have been passed would meet the standards specified

under S. 3180. (In consulting with our local bodies, it appears that states that have enacted legislation, as well as those that are evaluating proposals to go forward, are encountering the same problems that Congress has faced, particularly with respect to the issue of whether employers should be required to contribute to the cost of health care coverage and the difficult task of designing fair and equitable financing systems.) Florida is a voluntary system until 1994 and it is unclear what will happen after that. Minnesota finances uncompensated care by imposing surtaxes on health care services, thereby disproportionately penalizing those that already are providing health care protection. Thus far, Vermont is in the study phase of developing legislative alternatives.

Not only have most of the state initiatives been inadequate to address the full scale of the health care crisis, the means by which states have proposed to finance these initiatives have been, in our view, inequitable.

In New Jersey, the state government placed a surcharge amounting to 19.4 percent on all hospital bills in order to pay for the provision of uncompensated care for the state's nearly one million uninsured. New Jersey's labor leaders opposed the plan, arguing that the tax forces unions and employers who are paying their fair share to subsidize their competitors, employers who refuse to provide health care protection to their workers. The state AFL–CIO and 14 other labor organizations and unions filed suit against the plan. On May 27, 1992, the U.S. District Court issued a landmark decision in *United Wire. Metal & Machine Health and Welfare Fund* v. *Morristown Memorial Hospital* concurring with the labor movement's reasoning.

Prior to the enactment of the state surcharge, union representatives in New Jersey made a strong case for passage of legislation requiring all employers to do their fair share and financing any gaps in coverage equitably across the entire population. Union representatives in Florida and Minnesota made similar arguments when health care legislation was being considered in their respective states. In all cases, these principles were rejected in favor of more expedient political compromises. With health care costs skyrocketing all over the country and dramatic increases in the number of uninsured individuals, our members fear that other states will seek ERISA waivers to pursue regressive approaches to finance uncompensated care without being able to address the larger issues that underlie the health care crisis.

CONCLUSION

In our view, health care reform is the responsibility of government, employers and individuals and we are committed to the following principles:

- All Americans must be entitled as a right to a core benefit package,
- All employers must contribute fairly to the cost of care, and
- Financing must be based on an equitable and progressive basis.

While we are supportive of the goals that motivated the sponsors of the State Care Act, we feel that past experience argues for a national, rather than a state-based approach to national health care reform. While the goal of expanding access is one that we have long advocated, we are concerned that there is nothing in the legislation requiring all employers to do their fair share, thereby eliminating the competitive advantage of not providing health care coverage. We also are concerned that by establishing goals for coverage that are less than 100 percent, we will postpone longer than necessary the achievement of universal access.

We are prepared to join with the sponsors of the legislation and the other members of this Committee to continue discussions about how to achieve the goals set out in the legislation.

AMERICAN FEDERATION OF LABOR AND
CONGRESS OF INDUSTRIAL ORGANIZATIONS,
Washington, DC, September 25, 1992.

Hon. GEORGE J. MITCHELL, *Majority Leader,*
U.S. Senate,
Washington, D.C.

Dear Senator Mitchell: I would make several points in response to your question about whether the fiscal condition of states will prevent them from going forward leaving the majority of citizens uncovered and, thus, increasing the pressure for national reform:

1. The enactment and successful experience with the Hawaii program has not been a major factor in the growing support for reform.

2. Demonstration programs funded by the Robert Wood Johnson Foundation to expand access have been launched in a number of states. In general, participation has been far below expectations.

3. Several years ago, Massachusetts passed a pay or play system. The combination of the state's economy and the change in political leadership have virtually doomed the program. At the time of passage, the Massachusetts initiative was heralded as a major step toward national action.

4. A number of states have launched various initiatives, which have served only to draw attention to the possibility of broader state action.

In supporting S. 3180, various Governors have made the point that they are in a better position to break the political deadlock. Unfortunately, the experience with states that have acted has not borne this out. It appears that the states are having the same difficulty that Congress is in addressing the fundamental issues, such as mandating employer participation in the system and passing fair taxes to fund it. Assuming that this remains the case for the near future, then state initiatives will not have the track record and precedent value as they did for passage of Social Security. The result, therefore, would be to put off rather than advance national reform.

Sincerely,

KAREN IGNAGNI, *Director, Employee Benefits Department.*

PREPARED STATEMENT OF SENATOR PATRICK LEAHY

Mr. Chairman, thank you for the opportunity to testify again before this Committee on states' efforts to provide quality, affordable health care to all of their citizens.

The fact that you are holding this hearing today gives me hope. We owe so much to the governors here today. When faced with an Administration unwilling to move on national health care reform, these governors did not give up. Instead they went to work, and today are serving as an engine to move the country toward a goal all of us share.

In states as different as Vermont, Minnesota and Florida great changes are taking place. In these states, and many others, people from all walks of life are urgently calling for health care reform, and state governments are responding with sweeping reform laws.

That is why we are here today—to learn what these courageous states are doing to provide more affordable health care to their citizens and to determine what changes we need to make in federal laws so that they can succeed.

Making sure that states do succeed is what the State Care bill Senator Pryor and I introduced (S. 3180) is all about. I am honored that so many members of this committee have joined us in this effort.

Can states succeed at comprehensive health care reform without changes in federal law and regulations? Not according to the General Accounting Office and the Employee Benefit Research Institute. Both have studied the issue and concluded that state reform initiatives are seriously constrained by federal roadblocks.

The governors we will hear from today will add to that research with concrete examples of the obstacles they face. I am proud that my governor Howard Dean—the only physician governor in the country—is here today to talk about the Vermont prescription for reform and the help our state will need to put its universal health care plan into place.

The purpose of our State Care bill is to remove the federal roadblocks for states like Vermont that are committed to overhauling their health care systems. Let me briefly explain the major provisions of the bill.

Through a new federal commission, states with comprehensive reform plans can apply for limited waivers from Medicare, Medicaid and the Employee Retirement Income Security Act (ERISA) provisions. The federal commission will approve demonstration projects, oversee implementation, and have the authority to revoke waivers and terminate demonstrations for good cause.

To be eligible for the waivers, states must submit a plan to the federal commission that is comprehensive and meets strong access, cost containment and quality assurance criteria. Our bill authorizes up to 10 state demonstrations.

Over the past few months we have worked closely with many groups, Families USA, the Children's Defense Fund and the National Governors' Association in particular, to strengthen the protections for Medicaid beneficiaries contained in the State Care bill. We have clarified language in the bill requiring states to provide mandatory Medicaid services to Medicaid beneficiaries. We have strengthened provi-

sions that assure the high quality and availability of care for Medicaid beneficiaries. I want to thank these organizations for their contributions and their willingness to continue to work on these provisions with us.

We also have worked hard to carefully construct the most controversial and the most important provisions in the bill—the changes to ERISA. Our bill enables states that are approved under this demonstration program to broaden their current funding base to support access initiatives, but only if the assessments are broad-based. States cannot single out ERISA plans. We also allow states to establish a standard benefit package for employers in the state, with one important exception. Employers with self-funded health benefit plans would be exempt from this provision as long as their benefit package meets a minimum value.

We have included these and other provisions in the bill to recognize the legitimate concerns of business and labor. Our goal is to help states expand access to care, not diminish it, and the ERISA provisions are absolutely essential to the success of state reforms.

There are those who will oppose this legislation on the grounds that it will slow progress toward national health care reform. I disagree. I, too, am a strong supporter of the Majority Leader's efforts to develop and pass comprehensive health care reform legislation as soon as possible. But I agree with the Majority Leader, who has cosponsored the State Care bill, that letting states move ahead with their own comprehensive approaches is consistent with that goal, not a deterrent to it.

I would go one step further. I am willing to bet that states across this country, if given the tools to work with, will prove to be the engine to drive through what will eventually be health care for all Americans.

We cannot stop states from going forward with their health care reforms—they are already doing it. But we can prevent them from succeeding if we are not willing to remove the federal obstacles that stand in their way.

Attachment.

THE STATE ROLE IN COMPREHENSIVE HEALTH CARE REFORM

THE STATE CARE ACT

SUMMARY OF MAJOR PROVISIONS OF LEAHY/PRYOR BILL

PURPOSE: To encourage and assist state-based comprehensive health care reform efforts by developing a streamlined and expanded "one-stop-shop" waiver approval process that removes overly burdensome administrative, regulatory and statutory Medicare, Medicaid and ERISA (Employment Retirement Income Security Act) requirements.

1. STATUTORY AUTHORITY

Adds new Title to the Social Security Act establishing demonstration projects.

2. WAIVER AUTHORITY

Establishes a Federal Commission to review, approve and oversee State Care demonstration projects. The President will appoint, and the Senate shall confirm, members of the Commission. The Commission will be made up of representatives of: consumers of health services, small and large employers, state and local governments, labor organizations, health care providers, health care insurers, experts on the development of medical technology, as well as the Secretaries of Labor and Health and Human Services.

3. STATE CARE DEMONSTRATION GRANT APPLICATIONS

Establishes standards for approval of up to ten state demonstrations. Each application must have:

* Statewide applicability.

* Universal access for state residents, as defined by the state having to increase, by the end of the five-year period, the percentage of the insured to at least 95 percent of the population OR increase the population of insured by 10 percentage points. (For example, from 82 percent to 92 percent; the 10 percentage point increase clause is designed to be fairer to states with higher numbers of uninsured.) States applying would also submit a plan outlining how any remaining uninsured would be covered following the conclusion of the 5 year demonstration.

* Effective cost containment mechanisms that assure that health care inflation within the state does not exceed the average annual percentage increase in the gross domestic product plus 3.7% for 1994, 2.7% for 1995, 1.7% for 1996, .7% for 1997, and for each year thereafter, 0 percentage points.

* Federal budget neutrality over the five year demonstration period, although need not be budget neutral in individual years as it relates to Medicaid. In no year, however, can Medicare spending exceed projected expenditures under current law. (Constant and Possibly Improved Federal Funding Stream: States that have approved comprehensive health reform plans will be assured of at least the same Federal Medicaid match as would have otherwise been made over the five year period. As a result, any future Federal savings from Medicaid cuts/policy changes/reforms for that state would accrue to that state's benefit.)

* Inclusion of a common benefit package which is at least equal to one of the two benefit packages (standard -- with Rx drugs and basic) included in S. 1872 and which requires the inclusion of certain preventive services. Preventive and primary care services should be emphasized.

* No alteration of Medicare benefits and mandated Medicaid services to required populations.

* Strong quality assurance provisions for both the Medicare and the Medicaid programs.

* Provider licensing, quality control/assurance procedures, and transition procedures.

* Specific recommendations as to how state will meet long-term care service needs of chronically ill citizens of all ages.

* Specific recommendations as to how state will address its medical liability issue.

* Working in conjunction with the Commission, a health care data base/infrastructure to gather data on cost, coverage, resources (i.e., availability and distribution of health care personnel and technology), health care needs, and medical outcomes.

* A list of all Federal waivers necessary to achieve access and cost containment goals identified, with rationale for needing such waivers.

4. STATE REFORM PLAN DEVELOPMENT AND APPROVAL PROCESS

Requires states developing State Care demonstration projects to do so through a State Health Care Authority, or some equivalent body, composed of representatives of affected interests, including small and large business, consumers and labor, health care providers, insurers, state legislative leadership and other organizations determined appropriate by the governor.

States that have enacted comprehensive health care laws within 12 months of enactment of this legislation are exempted from this provision.

Requires state legislative approval of its comprehensive reform plan.

5. DEVELOPMENT AND IMPLEMENTATION GRANTS

The Commission is authorized to provide up to $2 million per approved state for one or more of the following purposes:

1. Establishment of infrastructure necessary to measure and evaluate success in achieving cost containment and access goals; and/or

2. Consolidation of health care budgeting, regulating, financing, and delivery responsibilities of state.

6. APPROVAL OF DEMONSTRATION PROJECTS

The Commission will give preference to state applicants that present a wide variety of characteristics, including states:

-- from a variety of geographic areas
-- with a high percentage of the total population living in rural areas
-- with a high percentage of the total population living in urban areas
-- with large and diverse ethnic populations

-- with large and small populations of people
-- which demonstrate an especially useful or novel approach to health care financing and delivery.

The Commission will provide for timely approval of demonstration projects. Specifically, the initial review by the Commission must be completed within 40 days of the original receipt of application. At that time, the Commission will notify the state about likely final approval status of application and request any additional information necessary to improve likelihood for approval. Final decision by Commission will be made within 60 days of receipt of additional state information following initial review.

7. MEDICARE, MEDICAID and ERISA WAIVERS

For states with approved applications, the Commission has the authority to waive certain requirements and/or other provisions of Medicare, Medicaid and the Employee Retirement Income and Security Act (ERISA) for the entire period of the demonstration (five years). More specifically, with regard to this streamlined and expanded waiver process:

1. Medicare: Affirms and assures states' ability to utilize Medicare waivers to strengthen the negotiating hand of the states with its health care providers. (E.G., an all payors mechanism, similar to the Maryland model, could be used and expanded for containing provider costs). AGAIN, NO ALTERATION OF BENEFITS WOULD BE PERMITTED.

2. Medicaid: Eliminate complex applications and renewal processes within the Medicaid program for existing waivers. In addition, expand Medicaid waiver authority to allow states to implement innovative reimbursement, service delivery, cost containment, and other reforms.

3. ERISA: In order to provide necessary financing and regulatory flexibility to states committed to comprehensively addressing cost containment and access problem, a narrowly crafted ERISA waiver authority would be granted by the Commission to qualifying states. Specifically, eligible states would not have the following reform provisions of a state law preempted by current ERISA law:

   A. Financing authority used to:

      1. Collect assessments for purposes of equalizing contributions across health care plans.

      2. Provide subsidies to persons without insurance and/or who are difficult to insure.

      CURRENT LANGUAGE:

      "Section 524(b) of ERISA is amended by adding:

      "(9) Nothing in this section shall be construed to preempt state laws which cause equitable fees, taxes, charges, or other payments to be paid by employers, providers, or other entities; even though the incidence of such payments may eventually be on employee benefit plans; so long as the incidence of such payments is not solely on employee benefit plans, or solely on goods or services purchased exclusively by employee benefit plans."

B. Requirements that set forth the manner and contents that a standard benefit package is offered or provided by employers. A self-insured benefit plan (both multi-state and in-state) would be exempted from fulfilling requirement of this standard benefit if it meets a minimum per-employee dollar value standard. Specifically:

A state standard benefit package would not apply to an employee benefit plan "that is not fully insured (self-insured) and that is a plan for which state laws would otherwise be preempted under Section 514, provided that such employee benefit plan has a benefit package for which the employer's per-employee contribution is determined by the Commission to be equivalent within that state to a national average value of at least $1,250 for an individual and $2,500 on a family (indexed to the state's wage growth)."

C. The development and implementation of a common administrative procedure (i.e., uniform claims forms and billing systems), an electronic claims processing procedure, hospital and other health care provider data collection mechanism, and a utilization review, quality assurance, and medical outcomes mechanism.

D. Negotiated health care provider reimbursement rate/system.

E. **THIS WAIVER AUTHORITY COULD ONLY APPLY TO HEALTH BENEFITS AND NO OTHER ERISA PREEMPTIONS, SUCH AS PENSION AND NON-HEALTH WELFARE BENEFITS, COULD BE WAIVED.**

8. EVALUATIONS, MONITORING AND COMPLIANCE

Approved states shall submit an annual report on their progress in meeting the cost containment and access requirements detailed in their plan. For states who are not meeting plan requirements, the Commission shall develop, in conjunction with the states, a corrective action plan. For good cause, the Commission has the authority to revoke waivers and terminate demonstrations. Should the Commission choose to take this course of action, states may ask for reconsideration within 30 days of announcement of proposed termination. The Commission then has 30 days to make final decision.

9. COST

As previously mentioned, the State Care plan is subjected to strict annual Federal budget neutrality as it applies to Medicare, and Medicaid expenditures will be no more than the current projected amount over the period of demonstration. (States may use savings derived from the changes in the Medicaid program for use in expanding coverage, to the extent that the overall Medicaid expenditures for the duration of the demonstration are no greater than what they would have been without the demonstration.)

Commission is directed to make recommendations about advisability of increasing Federal financial assistance for state comprehensive health care reform initiatives, and to make recommendations with regard to the amount and source of financing.

For states who have submitted a State Care application which does not meet the Federal budget neutraliy provisions described previously, and for whom the Commission views the application as

meritorious and deserving of approval, the Commission is directed to make a specific recommendation to the Congress for the appropriation of additional funds for this project. (Nothing in this section precludes a state from directly petitioning Congress for financial support for their program.)

10. OTHER RESPONSIBILITIES OF FEDERAL COMMISSION

The Commission is required to develop a model benefit package that could be used by states applying for this demonstration.

The Commission is required to develop guidelines for a health care data base/infrastructure to gather information on cost, coverage, resources (i.e., availability and distribution of health care personnel and technology), health care needs, and medical outcomes.

If, at the conclusion of the 5-year demonstration, no national, comprehensive health care system has been established, the Commission is required to make specific recommendations to the President and the Congress on establishing a national health plan, which utilizes the experiences of the state demonstrations.

PREPARED STATEMENT OF JOSEPH LIU

Chairman Bentsen and Members of the Finance Committee: On behalf of the children's Defense Fund, I would like to thank you for inviting us to testify on legislation regarding state health care plans and state flexibility in the Medicaid program. The children's Defense Fund is a non-profit charity whose mission is to provide a voice for children who cannot vote, lobby, or speak for themselves. For over twenty years, we have worked with this Committee to improve and strengthen the Medicaid program to provide health care for the nation's poorest and must vulnerable children.

CDF has long been a strong proponent of appropriate state flexibility to improve Medicaid coverage for low income Americans. For example, we fully support the Medicaid Eligibility Simplification Act, S. 3212, introduced by Senator Chafee and Senator Bradley which provides state flexibility to remove bureaucratic obstacles to eligibility for the program. Over the past several years, along with the states, we advocated for eligibility options allowing states to cover previously ineligible groups of low-income pregnant women and children. Those options and the positive response of the states were critical to enactment of the Medicaid coverage levels for children and pregnant women we have today.

However, the Children's Defense Fund has grave reservations about authority to waive or set aside protections in Medicaid proposed in S. 3180, the State Care Act, and S. 3191, the Medicaid Coordinated Care Improvement Act of 1992. Neither bill would create authority to provide coverage or additional benefits to pregnant women or children who could not be covered under current law. Yet, the bills allow the elimination of hundreds of beneficiary protections built into Medicaid over the past 25 years. Unless these changes are carefully crafted to allow only narrow waivers with strong safeguards, these bills could have a devastating impact on low-income families.

Medicaid now covers all pregnant women and children under age 6 with income below 133 percent of the federal poverty level and all children age 6 to 9 with income below the poverty level. The mandate to cover all children below poverty born after September 30, 1983, will eventually mean that no poor child will lack health care coverage—though ten years is too long to wait for health care coverage. Furthermore, changes in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program mean that children in Medicaid are entitled to all medically necessary services even if the services are not otherwise covered in a state's Medicaid plan.

The importance of the Medicaid reforms fashioned by this Committee in recent years cannot be overstated. Medicaid covers one in five children in the nation and finances the delivery of 40 percent of the nation's infants. The vital role of Medicaid is best illustrated by changes in children's insurance coverage patterns during this recession. Between 1990 and 1991, though the number of poor children increased by more than 900,000 and more than a quarter million children lost private health

insurance, the number of uninsured children actually decreased. The decrease in uninsured children is due entirely to increased coverage by Medicaid.

Current law gives states flexibility to provide Medicaid to uninsured pregnant women and children beyond the mandated levels. Section 1902(r)(2) of the Medicaid statute allows states to ice more liberal methods of treating income when determining the financial eligibility of low income children and pregnant women. Using this provision, Minnesota has been granted approval by the Health Care Financing Administration to disregard significant portions of family income to provide Medicaid with federal financial participation to all pregnant women and children with gross family incomes below 275 percent of the poverty level. Similarly, Washington state will disregard all family income above AFDC levels to provide Medicaid for all children under age 19 with family incomes below poverty. This Committee has already given the states the tools necessary to solve the problems of financial access to health care for the nation's children and pregnant women. For these populations, additional flexibility is not needed, nor is a broadening of the categories for which federal financial participation is available. That is why S. 3180, as currently drafted, can only hurt and not help pregnant women and children.

The State Care Act seeks to enable states to establish universal health care coverage and cost containment. The State Care Act is well-intentioned and we appreciate Senator Pryor and Senator Leahy's willingness to consider our concerns. Some of the most serious problems with the bill as introduced—such as conversion of Medicaid to a block grant—were deemed drafting errors and will be corrected.

However, it is deeply flawed. First, the bill provides overly broad authority to waive beneficiary protections in Medicaid. Second, it is not conditioned on universal health care coverage. The states only need to reach a 10 percent increase in insured residents. Third, the cost containment provisions are undefined and could lead to enormous new pressures to cut back on Medicaid and public health services.

To the extent the bill would allow states to regulate self-insured health plans, it is a step forward. Blanket exemptions from state regulation mean that self-insured health plans can refuse to honor medical child support orders against absent parents and that basic services such as childhood immunizations are excluded. Recent court cases have invalidated state taxes on medical providers and struck down state uncompensated care pools. The ability of states to regulate self-insured plans is also a prerequisite to meaningful cost-containment and reduction of cost-shifting.

We agree that some waivers of Medicaid law are necessary to provide federal financial participation to cover low-income adults. coverage of poor children is important, but children need healthy parents just as much as they need good health themselves. The incremental improvements in Medicaid have yet to reach non-pregnant adults and we support efforts to provide coverage to these ineligible groups.

However, the State Care bill would allow waivers of any requirements in §1902 and §1903 of the Medicaid statute. Such broad authority could eviscerate protections built up over the past 25 years. These protections include limits on cost-sharing for beneficiaries. A small copayment or deductible to a middle income family can be an insurmountable barrier to care for low income families. Quality standards for physicians, hospitals, laboratories, and nursing homes and due process protections and privacy standards could also be waived under the bill. The State Care bill would also waive provisions that are unrelated to health care coverage and costs such as a requirement that states may not reduce AFDC payment levels below those in May 1988.

The Democratic-sponsored Health America bill, S. 1227, and the Senate Republican Health Task Force proposal, S. 1936, include broad waiver authority, too. However, the waiver authority in those bills is in the context of substantial health care reform that would insure nearly all Americans. The State Care Act does nothing of the kind. States would be eligible for waivers for promising just a 10 percent increase in the number of insured residents.

Another problem is that the cost containment provisions of the State Care Act are dangerously vague. As introduced, the bill sets stringent limits on statewide health care expenditure growth. Yet, states would have little control over private health care utilization and no authority to control Medicare costs. In all likelihood, a state would only be able to cut back on Medicaid to meet the health expenditure targets set out in the bill and the burden of cost containment would be borne solely by low income families.

Any authority to waive requirements of the Medicaid statute must be limited to providing coverage for additional persons who may not be covered under current law. Any waivers must be carefully selected and narrowly targeted by this Committee. A blanket waiver with a handful of exceptions will provide little protection to the groups this legislation is intended to benefit. Without careful deliberation, waivers threaten the precious gains children and pregnant women have made over the

past few years. Just as Medicare eligibility, benefits, and protections are unchanged by this bill, no waivers of eligibility, benefits, or protections for children and families under Medicaid should be allowed.

The Medicaid Coordinated Care Improvement Act of 1992, S. 3191, would also set aside a number of key protections. The central provisions of the bill allow states to force Medicaid beneficiaries into managed care plans that only enroll poor people. The bill threatens beneficiaries' quality of care and exposes hundreds of millions of dollars of federal Medicaid funds to fraud and abuse.

The Children's Defense Fund does not oppose managed care. However, the history of Medicaid is full of prepaid Medicaid-only health plans that deceived and underserved beneficiaries, failed to pay providers, and left the bill for their profiteering with the public treasury. When California instituted managed care in the early 1970s, it led to scandals that cost tens of millions of dollars in public funds. More recently, the General Accounting Office concluded that Chicago-area managed care plans were so poorly structured they created an incentive to underserve. GAO also concluded that the Illinois state Medicaid agency failed to conduct even basic monitoring and oversight of the quality of care in those plans. It was only after the *Chicago Sun-Times* published an expose on the two plans' unethical and fraudulent marketing practices, delay of care to children, failure to provide follow-up to high-risk infants, and malpractice problems did the state take any action. In Philadelphia, a profitable Medicaid managed care plan declared bankruptcy and left over $60 million in unpaid bills from area hospitals. In Milwaukee, contracts with managed care plans were so vague, the plans did not provide immunizations. The result was an outbreak of measles in the community almost exclusively among children enrolled in these Medicaid managed care plans. S. 3191 provides little protections against the recurrent problems.

Managed care as proposed in S. 3191 employs none of the quality incentives of a commercial or non-profit HMO. Since Medicaid beneficiaries would be required to enroll under S. 3191, the managed care plan would not have to compete for their business. Since beneficiaries could not disenroll to a better plan, the plan does not have to fear losing enrollees. And since Medicaid pays so little, savings from greater efficiency would provide inadequate profit. The logical and inevitable result of such a system is pressure to reduce the amount and quality of services.

This new brand of managed care plan will have no incentives to provide quality care. Their market niche will be the regulatory vacuum created by S. 3191. And their profits will be based on undeserving low-income women and children. Quite simply, they represent Medicaid mills in reverse—fraudulently denying services without regard to medical need in pursuit of profit.

This legislation also threatens the very existence of community and public health programs such as school health programs. School health services have received broad bipartisan support and were a featured recommendation of the Steelman Commission's report. School health services may be the key to caring for the tens of millions of children who live in communities with inadequate health resources. Yet, this legislation threatens to defund nearly every school health program in the nation and prevent anymore from starting-up by shutting off reimbursements for services provided to Medicaid enrolled children. With children locked into managed care plans—nearly all of whom refuse to contract with community and public health programs—services provided in school clinics would no longer be reimbursed by Medicaid. That would harm both Medicaid enrolled children and uninsured children who rely on these programs for their health care.

Senator Moynihan's staff has spent a great deal of time with us on this legislation and it is much better than S. 2077. The bill has requirements for grievance procedures and external quality reviews. While such procedures are useful, our experience with Medicaid managed care has shown that poor families seldom file formal grievances when they encounter problems and state Medicaid programs seldom require plans to correct problems found in quality reviews.

S. 3191 requires the Secretary to promulgate financial solvency standards for all risk-contracting entities, including partially-capitated programs which are essentially unregulated in current law. However, states would not have to wait for the regulations to be issued under the bill. At an absolute minimum, states should not be allowed to move forward before regulations on financial solvency are issued. In addition, every contract should be reviewed and approved by the Health Care Financing Administration since hundreds of millions of dollars of federal funds are at stake in these contracts.

In conclusion, the Committee must move carefully before allowing exemptions and waivers from federal Medicaid law. Too much is at stake for pregnant women and children to set aside twenty years of protections and gains simply for the sake of greater state flexibility. The danger of undoing the tremendous progress this Com-

mittee has made on providing health care for children is too great. Poor mothers and children are the most dependent on Medicaid's benefits yet they consume the least Medicaid expenditures. If safeguards are not clearly and explicitly assured, the state flexibility bills before this Committee will cause more harm than good.

PREPARED STATEMENT OF SENATOR GEORGE J. MITCHELL

Mr. Chairman, I commend you for holding this hearing today to examine a number of proposals which are designed to help states as they attempt to expand access to health care for all of their citizens.

I believe access to affordable health care is a fundamental right in a democratic society. Yet it is a right that cannot be exercised by more than 35 million Americans. And it is a right that is being lost to nearly one million additional citizens each year.

The health insurance system in this country has broken down. It no longer affords peace of mind for parents who want to provide the best care available for their children or their parents or themselves.

I am committed to enacting comprehensive health care reform which will assure that every American has access to affordable health care while controlling the costs of care for the nation as a whole, for States and for families.

The Leahy/Pryor State Care Act is consistent with that commitment. This legislation will allow a limited number of states that have enacted comprehensive reforms, which are consistent with the fundamental requirements contained in my own legislation for access and cost containment, to take advantage of a streamlined and expanded waiver approval process for Medicare, Medicaid and ERISA waivers.

The bill is the second generation of a provision included in HealthAmerica, as reported out by the Senate Labor and Human Resources Committee which allows states to opt out of employer-based health care reform as long as certain cost containment and access criteria are met.

This legislation is not a perfect solution to the problems faced by States attempting to implement comprehensive health care reforms. But it is a sincere effort to encourage and assist States as they attempt to control costs and provide access to care for all of their citizens.

We will also examine Senator Moynihan's legislation, the Medicaid Coordinated Care Improvement Act of 1992, which is intended to make it easier for states to offer managed care plans to their Medicaid recipients.

I support the intent of this legislation—to assure that Medicaid recipients have access to providers—which is not always assured through the fee-for-service model. However, in expanding Medicaid enrollment in managed care, it is important to pay particular attention to the quality of care provided. It is also important that solvency standards are established and enforced in an effort to protect both patients and providers.

We are pleased to have Senator Akaka with us today. Hawaii has been successful at providing access to health care for most of its citizens for more than 17 years. While the Hawaiian health care system is not perfect, it comes closest to what we hope to achieve for every American.

The legislative initiatives we will examine today are not a substitute for comprehensive national health care reform, but they are an important part of the health care debate.

While we, at the Federal level struggle with how best to reform the nation's health system, we must, and should, look to the States for ideas. Many of the States are struggling with the same dilemmas that we face in Washington. And yet, some states are at the forefront of implementing important reforms which will contain the escalating costs of health care while expanding access to those without coverage.

I hope we will be able to enact comprehensive national health care reform in the very near future. The legislation being reviewed today, if enacted, would give some states a "headstart" on national reform. It is my hope and my commitment to assure that every citizen of every state enjoys the peace of mind that 98% of Hawaii's citizens enjoy today.

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, I would like to thank you for holding this morning's hearing on state-based health care reform initiatives. As you know, I have worked with Senator Leahy for months to develop legislation designed to provide states the minimum

flexibility to enable them to design, enact and implement state-based comprehensive health care reforms.

The results of our effort were incorporated into S. 3180. This bill received widespread, bipartisan support of 15 Members of the Senate. I was particularly honored to be joined in this effort by some of the most distinguished leaders in the health care reform debate, including: the Majority Leader—Senator Mitchell, Senator Rockefeller, Senator Riegle, Senator Chafee, and Senator Danforth. We were also privileged to receive the endorsement of the National Governors' Association and the support of the Democratic Governors' Association.

Mr. Chairman, when it comes to health care, few of us are satisfied with, or accepting of, the status quo. We must find a way to achieve nation-wide, comprehensive reform of our health care system. Following the lead of Senator Mitchell, I remain committed to this end.

It is important to note, however, that the first choice of almost every Governor is for the Federal Government to meet the need for national health care reform. However, unlike many other interest groups, the second choice for Governors is NOT to do nothing. They don't have that luxury. They see and talk to their people in need every day.

It is, not surprising, therefore, that our Governors—like our constituents—are getting impatient with us. In fact, more than 15 states are working on massive, statewide health care reforms. At least four have actually passed legislation that begins to implement massive overhauls of their health care systems.

Unfortunately, according to a June, 1992 General Accounting Office report, as well as the testimony the GAO submitted for today's hearing, many—if not all—of the state-based health care reform initiatives cannot be successfully implemented without the removal of certain Federal statutory barriers. In effect, therefore, our inaction is not the only barrier to providing affordable health care to our citizens; CURRENT FEDERAL LAW actually provides a significant roadblock as well.

In particular, the GAO highlights ERISA—the Employee Retirement Income Security Act—and restrictive provisions of Medicaid as the major impediments to state-based comprehensive reforms. GAO suggests that the Congress consider passing narrowly crafted amendments to remove these barriers. The Leahy/Pryor bill does just that.

Mr. Chairman, all of our witnesses have much to offer. In particular, however, I would like to single out Senator Leahy. It has been an honor and a privilege to be a partner with him during the development of this legislation. We would not be here today without his leadership and persistence.

While we would not be here without Senator Leahy, the same could be said of the NGA, the DGA, and the Governors they represent. It is with great anticipation and appreciation that I look forward to the testimony of Governors Romer, Chiles, Dean, and Mickelson.

Finally, Mr. Chairman, it is with deep disappointment and, frankly, incredulation, that I note that the Administration chose not to accept your invitation to testify. I find it inexcusable that this Administration, which purports to support state-based health care reforms, could not even find the time or the people to come testify today.

Mr. Chairman, once again, I thank you for holding this morning's hearing. I would ask that you include in the hearing record a summary of S. 3180, my statement that accompanied the bill at the time of introduction, and the letter of endorsement from the National Governors' Association.

S. 3180, THE STATE CARE ACT OF 1992
SUMMARY OF MAJOR PROVISIONS

Establishment of State Care Demonstration Projects

- The bill establishes a federal Commission to consider State applications for 5-year waivers of specified provisions of Medicare, Medicaid and ERISA law to allow States to implement state-wide, comprehensive health care reform initiatives meeting certain criteria.

- The Commission provides for timely approval of demonstration projects, oversees implementation, and has the authority to revoke waivers and terminate demonstrations for good cause.

- Demonstrations are limited to 10 states.

- The Commission is authorized to provide implementation grants of up to $2 million to each approved State.

- The Commission consists of the Secretary of Health and Human Services, the Secretary of Labor, and 11 members appointed by the President and confirmed by the Senate.

Requirements of State Plans

In order to obtain Medicare, Medicaid and ERISA waivers, a state must:

- demonstrate that by the end of the five-year period, the percentage of the insured has increased to at least 95% of the population OR the insured population has increased by 10 percentage points. (The 10 percentage point increase clause is designed to be fairer to states with higher numbers of uninsured.) With either goal, coverage for children must increase at an equal rate.

- demonstrate that health care inflation within the State does not exceed the average annual percentage increase in the gross domestic product plus 3.7% for 1994, 2.7% for 1995, 1.7% for 1996, .7% for 1997, and for each year thereafter, 0 percentage points.

- develop a common benefit package which is at least equal to one of two benefit packages contained in Senator Bentsen's small group insurance reform bill.

- demonstrate that the project will be federal cost-neutral over the five-year period.

Waiver Authority

States that meet the above criteria would be eligible for the following waivers:

Medicaid. Waiver authority allows states to include Medicaid beneficiaries and Medicaid payment systems in plans to restructure health care finance and service delivery systems.

Protections for Medicaid Beneficiaries. States must provide mandatory Medicaid services to all groups current law requires States to serve. States must maintain safeguards currently specified in the Medicaid program (including procedures sufficient to insure the high quality and availability of care) to protect the health and welfare of Medicaid recipients.

Medicare. Waiver authority is very limited with respect to Medicare. The bill gives states the ability to include Medicare in all-payor negotiated rate systems for hospitals. Benefits to Medicare beneficiaries cannot be diminished.

ERISA. Waiver authority has been crafted narrowly to recognize the concerns of business and labor.

* Allows states to collect assessments from ERISA plans. States are prohibited from singling-out ERISA plans for assessment. The provision enables states to broaden their current funding base to support health-related initiatives, such as risk pools for the uninsured.

* Allows states to establish a standard health benefit package for employers in the state. However, employers with self-funded health benefit plans could deviate from the standard benefit package if the employer offers a health benefit plan with benefits equal to an adjusted $1,250 per individual and $2,500 per family. The provision enables states to establish a minimum set of health benefits for its residents.

* Allows states to develop common administrative procedures. The provision enables states to require both health insurers and ERISA plans to use the same procedures and processes in the areas of claims processing and quality assurance.

* Allows states to establish a negotiated system of hospital or other provider reimbursement rates to be used by both health insurers and ERISA plans.

NATIONAL GOVERNORS ASSOCIATION

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August 12, 1992

The Honorable David H. Pryor
United States Senate
267 Senate Russell Office Building
Washington, D.C. 20510-0402

Dear Senator Pryor:

On behalf of the National Governors' Association, we support the legislation introduced by you and Senator Leahy that would assist states in developing and implementing state-based comprehensive health care reform initiatives.

As you are well aware, Oregon, Hawaii, Florida, Minnesota and Vermont have taken important steps toward changing their health care systems by enacting and implementing state-based health reform strategies. In the next year we expect several more states to develop such comprehensive approaches. States are poised to move. However, most are prevented from making significant progress because of various federal statutes and regulations that limit state action. States cannot make the sweeping changes necessary without the help of Congress.

At a meeting with you and other members of Congress last June, Governors talked about the need for a state and federal partnership. We are pleased to see that your legislation recognizes that important relationship. Moreover, you have captured an essential component of the partnership — state flexibility and accountability within a vision of comprehensive health care. You and Senator Leahy are to be congratulated.

Waiver authority is key to affecting the needed changes. The legislation establishes streamlined waiver authority in Medicaid and Medicare and gives states the authority to test strategies that are currently precluded under the Employee Retirement Insurance Security Act (ERISA). Without such authority states cannot be expected to meet the goal of a comprehensive plan.

The legislation also removes a significant roadblock to state reform by establishing a commission that will facilitate the waiver approval process as well as give states a single place to secure waivers and receive technical assistance in the development of their demonstration applications. We believe that this is significant.

The National Governors' Association supports the legislation; however, several Governors have expressed concern about certain of its provisions. For example, ten demonstrations might be too few and federal cost neutrality over the five year waiver period may be too limiting. We look forward to working with you in the next few weeks to address these concerns. Finally, you have crafted a careful balance between state flexibility and accountability. If this legislation is to have its intended effect, that flexibility must be not be eroded.

The nation's Governors are committed to making quality health care affordable and available to all. We believe that through this legislation you have reaffirmed your commitment to that goal as well. We thank you for all of your efforts and look forward to working with you and other members of Congress to assure that this legislation becomes law.

Sincerely,

Governor Roy Romer
Chairman
National Governors' Association

Governor George S. Nickelson
Co-Chairman
Task Force on Health Care

Governor Howard Dean
Co-Chairman
Task Force on Health Care

cc: Senator Leahy

United States of America

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Senate

Mr. PRYOR. Mr. President, today I am pleased to join my friend and esteemed colleague from Vermont, Senator LEAHY, in introducing legislation to provide needed flexibility to States which are committed to comprehensively reforming th ir health care systems. We are honc ed to be joined in this effort by the majority leader, Senator ROCKEFELLER, Senator RIEGLE, Senator CHAFEE, Senator DANFORTH, Senator KERREY, Senator WELLSTONE, Senator ADAMS, Senator AKAKA, Senator BINGAMAN, Senator GRAHAM, Senator INOUYE, and Senator JEFFORDS.

Mr. President, everyone of us in this body is struggling to find a workable solution to the overwhelming health care challenges that confront our Nation. No one is satisfied with, or accepting of, the status quo.

There is no question that we must find a way to achieve nation-wide, comprehensive reform of our health care system. Following Senator MITCHELL's lead, I remain committed to developing and passing a workable and comprehensive national health care reform initiative at the earliest possible moment.

Unfortunately, to date, we have not been able to achieve consensus on a comprehensive health care reform package that the President will sign into law. It is fascinating to note, however, that there is a common thread that runs throughout virtually every significant health care reform proposal before us. Despite the differing and numerous alternative app roaches, every proposal provides for a significant amount of State flexibility and responsibility. This is the case with the Mitchell/Kennedy/Rockefeller/Riegle bill; it is the case with Senator KERREY's bill; it is the case with Senator WELLSTONE's bill; and it is the case with the Republican Health Care Task Force bill, whose primary author is the chairman of the task force, Senator CHAFEE. I am pleased to say that every one of the primary sponsors of these bills is joining with Senator LEAHY and me in introducing our legislation today.

Why is it that the major health care initiatives emerging from both sides of the aisle all assure a significant State role? I believe the answer is twofold. First, all of us want to ensure that our health care system is more accountable and responsive to local desires and needs. Second, and probably at least as important, it is because the States and their Governors have been the ones who have succeeded in progressing from talking about the problem to actually acting to solve it. In fact, more than 15 States are working on massive system-wide restructuring. At least four States have actually passed legislation that begins to implement massive overhauls of their health care systems.

Unlike the Federal Government, these States have sought and, to the extent possible, achieved consensus within their own borders. These achievements were not accomplished without controversy. They were also not achieved without political risk, leadership, and courage. Most importantly, though, they were achieved.

Unfortunately, according to a June 1992 General Accounting Office report, many if not all of the State health care reform initiatives cannot be successfully implemented without the removal of certain Federal statutory barriers. In effect, therefore, our Federal inaction is not the only barrier to providing affordable health care to our citizens; current Federal law actually provides a significant roadblock as well.

The purpose of the legislation we are introducing today is to remove those roadblocks for States that are committed to overhauling their health care delivery systems. Through a new Federal commission, our bill sets up a streamlined, "one-stop-shop" waiver approval process that provides narrowly crafted, but important, waivers from Medicare, Medicaid, and the Employee Retirement Income Security Act [ERISA]. These waivers are absolutely necessary to the success of state-based comprehensive health care reform efforts.

To be eligible to receive the waivers, States must submit a plan to the Commission that is comprehensive, and meets strong access, cost-containment,

and quality assurance criteria. States also must continue to provide Medicare services to the Medicare population and federally-mandated Medicaid services to Medicaid recipients.

Mr. President, we have worked for months with representatives of consumers, States, small and large businesses, and many others in developing this legislation. While our bill is not flawless, we believe it moves a long way toward striking a fair and reasonable balance between interested parties. Having said this, as we have been in the months prior to today's introduction, we remain open to constructive suggestions. In fact, we sincerely hope that our introduction of this bill will be taken as an open invitation for comments and suggested improvements.

To further the debate on this issue, I am particularly pleased that the chairman of the Finance Committee, Senator BENTSEN, is planning on holding a hearing on State-based health care reform initiatives in September. I would like to take this opportunity to thank Senator BENTSEN and his staff for the encouragement and technical support they have given me and my staff throughout the development of this bill.

Mr. President, there is no question that there will be those who will oppose this effort. They will cite a number of reasons, but I fear the real reason is that their second choice for health care reform is to do nothing. I do not believe we can accept or condone this position.

The first choice for restructuring our health care system, including the first choice of almost every Governor, is that the Federal Government meet the need for national comprehensive reform. However, if a divided Government ensures that we cannot gain consensus on the national reforms we so desperately need, we simply cannot continue to hold the States hostage to our gridlock.

Mr President, it is essential to remember, though, that this bill can, in some respects, work out as being the first choice of practically everyone. First, it can work to fill in some of the details of the previously introduced nationally, comprehensive initiatives. Second, waivers are not granted in any case unless the State-based effort is comprehensive in nature. Finally, while holding the States accountable for comprehensive, affordable, quality, accessible health care, it does not direct the States as to how they must achieve these criteria. In other words, advocates of single-payer approaches, advocates of employer-based approaches, and advocates of everything around and between might well see their approach embodied in one of the States' comprehensive efforts.

Mr. President, regardless of the approach, I cannot and I will not continue to look into the eyes of the Governors committed to comprehensive health care reforms and say, "Sorry, because we don't have a national solution, there can be no solution." If an individual State can come up with a program that assures access to quality, affordable health care to its citizens, who are we to stand in the way?

I have long felt that we, as representatives of the Federal Government, are all-too-frequently negative and overly paternalistic to State-born reform initiatives on almost any issue. Sometimes it seems that if the idea isn't ours, we always find a way to show that it somehow isn't good enough. Well, when it comes to health care reform, at least to date, we have not come up with anything better than what many of the States are offering. To the contrary, we have as yet to produce anything approximating comprehensive reform.

There is broad-based and bipartisan support for this important initiative. I am particularly pleased to report that, despite the fact that the Governor—like everyone else—were forced to compromise on many issues of importance to them, the National Governors' Association [NGA] has indicated its support of this bill. I would like to thank the NGA, as well as the Democratic Governors' Association, for their thoughtful and constructive suggestions.

Many other organizations, in particular, Families USA, have also been extremely helpful. I look forward to working with all interested parties to assure we have the strongest package possible.

I am also extremely pleased to note that Congressman WYDEN has already indicated his desire for introducing the companion legislation on the House side. Although not cosponsoring this legislation today, I would also like to thank Senator DURENBERGER for his interest and support of many of the concepts outlined in this legislation. Senator LEAHY and I are very encouraged by these developments. I urge all of our colleague to join Senator LEAHY, Congressman WYDEN, and me in our efforts to help the State help their, and our, constituents.

Finally, Mr. President, I would like to take one moment to say what an honor and a privilege it has been to work with Senator LEAHY and his fine staff on this bill. Today's introduction of our bill represents a vindication for his efforts and his commitment to change and restructure our health care system.

STATE OF ARKANSAS
OFFICE OF THE GOVERNOR
State Capitol
Little Rock 72201

Bill Clinton
Governor

September 4, 1992

The Honorable David H. Pryor
United States Senate
267 Senate Russell Office Building
Washington, DC 20510-0402

Dear David:

I appreciate the time and effort you and others have spent in developing the legislation introduced by you and Senator Leahy which outlines a process for assisting states to plan and implement state-based comprehensive health care reform efforts.

The "one-stop-shop" concept for waiver approval outlined in your bill will help states to truly perform the laboratory function in this area of health care reform as we seek to design an overall system of health care for all our nation's citizens. I appreciate the recognition the bill gives as well as your personal statements in recent weeks that the first choice for national health care reform is for the federal government to act, but in the interim this bill gives states the needed process for moving ahead.

I support your efforts in this bill toward moving us to a national solution and look forward to working with you further on this critical area of health care reform.

Sincerely,

Bill

Bill Clinton

PREPARED STATEMENT OF SENATOR DONALD W. RIEGLE, JR.

State and Federal governments clearly need work together on reforming our health care system, both now and in the future, as we move forward on reaching a consensus on national reform. More immediately, states face Federal statutory and regulatory barriers to implementing innovative plans and I want to continue to work with States on this. State experience is vital in helping us develop a comprehensive reform plan that can work. But I think we all agree that these state initiatives are not a substitute for national reform. Ultimately, the federal government must be involved to set uniform standards in place to control skyrocketing costs and to guarantee coverage for every American.

I want to commend Senators Leahy and Pryor for their leadership on S. 3180 of which I am a cosponsor. "StateCare" would provide states with the tools to move ahead with strong health care reform proposals that require waivers under Medicare, Medicaid and the Employee Retirement Income Security Act (ERISA). The proposal is consistent with HealthAmerica which would provide waivers for states with comprehensive plans that want to experiment with alternative systems. While I agree in principle with helping states with programs that are truly comprehensive, I remain concerned about a number of issues on which I would like to continue working on with the sponsors of the bill.

It's very important that criteria be established under the waiver process to ensure that plans have tough cost controls and universal access.

Universal access is critical to eliminate the current shifting of costs onto those who now have health insurance, including businesses and workers. While the bill (with standard of a 10% increase or 95% coverage) would require states to recommend plans for covering all uninsured, we must ensure that the plans are actually implemented.

Also, we need to ensure that all populations that are currently covered under Medicare and Medicaid continue to receive high quality care in any new plan and that such waivers are carefully structured and targeted. Children's Defense Fund and Families U.S.A. will testify later about Medicaid waivers.

Also, without a national plan and national standards, changes to ERISA which give states more authority to impose requirements on self-insured plans may unfairly treat businesses that are currently offering health care and their workers, especially if they would not benefit from the reforms. A state-wide approach by itself would create problems particularly for businesses that operate in many states. We will hear from the AFL–CIO and others today about these issues.

I want to emphasize that a state-by-state approach would not now be needed if we had the leadership from the White House to move forward comprehensive reform. Many of us, including Senators Leahy, Pryor, Mitchell, Rockefeller and myself, continue to work on developing a reform plan that would systematically reform our health care system.

PREPARED STATEMENT OF SENATOR JOHN D. ROCKEFELLER IV

Over the past year, I have had numerous meetings with both Democratic and Republican Governors on the need for health care reform. They know—as we all know—that the federal government must ultimately intervene and provide leadership on health care reform. The American people want and expect the federal government to take the lead role in assuring universal coverage and lowering health care costs.

To be honest, I was critical of the National Governors Association's recommendations on health care reform that were issued last year, because of its reliance on state experimentation. Frankly, I thought the Governors' missed an important opportunity to advance the debate on health care reform. But I certainly understand the politics that resulted in their recommendations.

My personal feeling is that we already know what the options are. Unfortunately, none of them are painless or easy. Any solution that provides universal coverage and would lower health care costs involves hard choices, tough decisions, and compromise.

President Bush made the politically easy, but financially irresponsible and morally indefensible, decision to rely on tax credits or vouchers. His plan preserves the status quo. By doing so, his plan leave millions of working families out in the cold. And, it does nothing to lower health care costs. George Bush relies on "encouraging" enrollment in managed care programs to lower health care costs. Yet, almost half of all employers are already enrolled in some form of managed care arrangement, and we have not yet seen any appreciable decline in our nation's health care tab.

In fact, CBO estimated that even if *all* Americans were enrolled in the *most stringent* types of managed care, such as staff- or group-model HMOs (which severely limit patient freedom of choice), this country's health care tab *might* be lower by only about 10 percent.

My Republican colleagues argue that Congress should do what they describe as "doable." In fact, they have a list of 11 items that they would like to see action on this year. Enactment of their 11 incremental items, instead of providing relief to American families, would only worsen the current situation if not done in the *context* of comprehensive reform.

Let me just emphasize that I am not holding out for a perfect solution—but I do intend to continue working vigorously for a *comprehensive* solution. And, under the strong leadership of the Majority Leader, Senator Mitchell, Senate Democrats are nearing agreement on a consensus proposal.

Having said that, I certainly understand that the Governors are anxious for immediate relief. Their budgets—which they must balance every year—are being eaten away by Medicaid and health care cost increases. And, they are seeing a growing number of their residents go without health care. As a former Governor, I appreciate their impatience and their frustration.

That is why I have joined with Senators Leahy and Pryor in legislation that would allow states to pursue comprehensive health care reform. I do not think that state-by-state reform is the preferred route to comprehensive health care reform. But, in this instance, I do not think the federal government should stand in the way of state efforts to provide coverage to their citizens and to lower health care costs.

In the past, states have led the way on health care reform. The Medicare DRG payment system was designed after an experimental payment system that was first implemented in New Jersey. States were the first to recognize the need to decouple Medicaid eligibility from welfare.

Minnesota, Florida, Vermont, South Dakota, and many other states, including my own state of West Virginia, have enacted comprehensive health reform, or have established high-level commissions that are preparing to make recommendations on how to achieve comprehensive reform. As long as important protections for Medicaid and Medicare beneficiaries are included, I hope that the Finance Committee will proceed to act on this legislation this year.

Prepared Statement of Robert S. Stone

Chairman Bentsen and members of the Committee, good morning. I am Robert S. Stone. I am pleased to appear before you today on behalf of The ERISA Industry Committee, generally known as ERIC. I serve as ERIC's Chairman, and have been active in ERIC's affairs since its formation shortly after the enactment of the Employee Retirement Income Security Act ("ERISA"). I also serve as Associate General Counsel to IBM in Armonk, New York, where I have been responsible for the legal issues affecting employee benefits since 1973.

The ERISA Industry Committee (ERIC)

ERIC represents the employee benefits interests of the nation's largest employers. Virtually all of ERIC's members employ more than 10,000 employees, and a number of them have hundreds of thousands of employees. As sponsors of health, disability, pension, savings, life insurance, and other benefit plans covering approximately 25 million participants and beneficiaries, ERIC's members have a strong interest in the success and expansion of the employee benefit system in the private sector.

All of ERIC's members do business and provide health and retirement plans in more than one state, and some have operations and employees in all fifty states. Transfers of employees from one state to another are common. The plans sponsored by ERIC's members generally provide uniform benefits in all states where beneficiaries are located. Nationwide benefit uniformity reduces plan costs, reduces the contributions that employees and employers must make to finance their benefit plans, and enables a multi-state employer to devote a higher percentage of its benefit budget to benefits rather than to administrative expenses.

ERIC members sponsor benefit plans that set the standard for comprehensive employment-based health care coverage. All of ERIC's members provide comprehensive health care coverage to their employees. Together, they provide coverage to approximately ten percent of the U.S. population.

ERIC'S POSITION ON HEALTH CARE REFORM

ERIC recently published its *Interim Policy Statement on Health Care System Reform*, which we are pleased to submit to the Committee for the record together with our written statement. The 27-page *Interim Policy Statement* reflects broad consensus within ERIC's membership on the following general principles of health care system reform:

- A public-private partnership encompassing payers, providers and patients to design and implement reform;
- A comprehensive strategy for making the health care system coherent, efficient and cost effective;
- An opportunity for employers to voluntarily continue to be the primary source of health care coverage for their own employees and their employees' dependents; and
- Federal leadership in establishing a national health care policy.

It is significant that the general principles include the following two requirements for health care system reform:

> First, health care system reform must be comprehensive rather than piecemeal.
>
> Second, health care system reform must be carried out pursuant to a comprehensive federal policy.

ERIC's *Interim Policy Statement* concludes, and our members strongly believe, that America's health care system can become coherent, efficient, and cost-effective only if reform is carried out pursuant to a comprehensive federal policy rather than as the result of diverse state action. The *Interim Policy Statement* states that the absence of a coherent national policy, the encouragement of state experimentation or reliance on other piecemeal incremental approaches are likely to further fragment the health care system and increase costs.

ERIC OPPOSES PROPOSALS TO UNDERMINE NATION-WIDE UNIFORMITY

ERIC opposes legislation such as S. 3180 that would undermine ERISA preemption of state laws relating to employer-sponsored health plans. Such legislation is inconsistent with the general principles for health care system reform in ERIC's *Interim Policy Statement*. Specifically, the legislation is fundamentally incompatible with comprehensive health care system reform in accordance with a coherent national policy. If enacted, the legislation will be a step backward, not forward, on the road to reform.

WEAKENING ERISA PREEMPTION WILL TURN BACK THE CLOCK ON LANDMARK FEDERAL REFORM LEGISLATION.

The enactment of ERISA in 1974 was a milestone in reform of federal employee benefit policy. ERISA established uniform federal standards for a broad range of employee benefit plans, including health plans.

ERISA regulates the pension, health, and other welfare benefit plans that employers establish for their employees, and treats employee benefit plans as exclusively a federal concern.

Prior to the enactment of ERISA, employee benefit plans were regulated by a patchwork quilt of state statutes and state common-law rules. An employer that sought to maintain a uniform employee benefit plan for a multi-state workforce encountered severe administrative difficulty and expense in complying with rules that differed from state to state. The employer often was prevented from providing its employees with the best possible benefits at the most reasonable cost. Often employees transferred from one state to another encountered difficulties in carrying with them the same coverage and benefits on which they depended.

In recognition of the hardships and inequities that employees and employers suffered under state regulation, Congress included in ERISA a broad provision preempting state laws relating to employee benefit plans. The legislative history of ERISA confirms what is clear from the plain language of the statute itself: that Congress intended to preempt state laws that apply to all ERISA-covered benefit plans, including health plans.

ERISA's preemption of state laws that relate to employee benefit plans is essential to the fundamental policies of ERISA and the effective administration of voluntary employer-provided health care coverage. ERISA provides national uniformity in the regulation of employee benefit plans and promotes the growth and soundness of these plans through exclusive federal regulation under a unitary legal regime.

If states are permitted to enforce a crazy-quilt of laws against health plans, employees and employers alike will suffer. Employers will reduce the benefits that their plans provide in order to keep costs at acceptable levels. Employees, who generally contribute to their employers' health plans, will find that their contributions will increase, that their benefits will be reduced, or both.

ERISA preemption thus encourages both employees and employers to achieve the best possible benefits at the most reasonable cost, and thereby advances a fundamental reform made by ERISA: national uniformity in benefit-plan regulation. That reform is responsible for the substantial employer support for health benefit coverage: today approximately 150 million employees and their dependents are covered by employer-sponsored health plans.[1/]

THE NEED FOR HEALTH CARE REFORM IS A NATIONAL NEED THAT REQUIRES A NATIONAL SOLUTION.

There can be no doubt that the U.S. health care system has serious problems. Each year billions of dollars in health care expenditures are wasted on inappropriate or poor quality health care. The rapidly escalating cost of health care has forced both private and public payers to reduce coverage, shift costs to other payers, or require individuals to assume a greater share of total costs. Cost-shifting among payers has exacerbated the increasing cost of health care for most payers, which has further eroded coverage. As a result, millions of Americans lack reasonable access to basic health care or lack the financial resources to obtain care, except through inefficient settings such as hospital emergency rooms or through already overburdened public health clinics.

In 1990 the nation spent over $666 billion on health care, equal to 12.2 percent of our Gross National Product. These figures are projected to increase: to $1,073 billion and 14.7% of GNP in 1995 and $1,616 billion and 16.4% of GNP in the year 2000.[2/]

The problems afflicting the health care system are national problems requiring national solutions. The business of health care in the United States is a national industry serving a national marketplace that is immersed in, and has a major impact on, interstate commerce.

State borders are largely irrelevant to the provision of health care in the United States. Much of the nation's health care is provided by major hospitals and medical centers, health maintenance organizations, practice groups, managed care networks, and other organizations that conduct business across state borders, serve markets that cross state borders, and that draw their personnel from multi-state regions. Other industries concerned with health care coverage are also largely interstate in nature.

[1/] Piacentini & Foley, EBRI DATABOOK on Employee Benefits at 215 (2d Ed. 1992) ("EBRI DATABOOK").

[2/] EBRI DATABOOK at 188, 194.

Similarly, a great many of the public and private health plans that finance health care coverage are interstate plans. Well over eighty percent of the nation's population is covered by a private or government health plan.[3/]

Many of the nation's employer-sponsored health plans -- which benefit over 60 percent of the nation's population -- cover the employees of multi-state employers.[4/] The largest employers, whose plans cover the largest numbers of employees, are overwhelmingly multi-state employers. As I mentioned earlier, all of ERIC's members -- whose health plans cover ten percent of the nation's population -- operate in more than one state and provide coverage to employees, retirees, and dependents residing in numerous states.

Similarly, the federal government -- which covers approximately nine million employees, dependents and annuitants under the Federal Employees Health Benefits Program (FEHBP) -- is a multi-state employer in its own right[5/] and, like Medicare, FEHBP has an impact on the cost and economics of private employer coverage.

The federal government's plans -- including Medicare, FEHBP, veterans hospitals and benefits and CHAMPUS, state and local government plans, non-profits, private sector employer plans and other arrangements all have an impact on one another. When any of these programs makes major changes in coverage and cost, the other plans feel the impact on quality and cost.

A multi-state industry of this magnitude, which has such a profound effect on the economy and which provides critical services to such a high percentage of the nation's population, cannot be left to a patchwork quilt of state regulation.

"BALKANIZATION" OF THE HEALTH CARE SYSTEM THROUGH STATE REGULATION WILL BE COSTLY, HARMFUL TO EMPLOYEES AND THEIR DEPENDENTS, AND DAMAGING TO THE NATION'S HEALTH CARE SYSTEM.

The key to successful health care system reform is a national policy that fosters improved health care quality, efficiency, and effectiveness. By contrast, state regulation of health care plans will "Balkanize" the regulation of health care by subjecting health plans to regulation by the laws of more than 50 different jurisdictions.

3/ EBRI DATABOOK at 218.

4/ EBRI DATABOOK at 218.

5/ EBRI DATABOOK at 288.

Balkanization will increase the cost of health care, increase the cost of plan administration, and prevent employers from providing uniform benefits to their employees on a nationwide basis.

Our health care system is already plagued by enormous inconsistency in the quality, efficiency, and cost-effectiveness of health care. Legislation that encourages individual states to pursue separate courses of action will promote conflicts between states, and between state and federal governments, and exacerbate the problems that now exist by inviting the states to take as many as 50 different approaches to the regulation of health care.

Since the federal government already manages, provides or regulates a substantial portion of the health care system, compatibility of private and public elements of the health care system can be assured only by the development of a comprehensive national policy.

Inconsistent state regulation will add significantly to the already high cost of providing health care coverage. Rules that vary from state to state will greatly increase the complexity of administering a multi-state health plan and will make it either impossible or far more expensive for a plan to offer the same coverage to all covered employees and their dependents, regardless of where they reside.

Faced with an array of conflicting state regulations and additional costs increases, employers will be forced to recoup the additional costs elsewhere. Some will curtail benefits, reduce other compensation, or terminate health care coverage entirely; others will pass the costs on to employees in other ways -- for example, by increasing the contributions that employees must make in order to obtain health care.

Even if a limited number of states seek to regulate health plans, employees in all states are likely to suffer. The additional costs that the state laws impose will not be borne solely by the employees who reside in those states. A multi-state employer that is burdened by the additional costs imposed by conflicting state regulations is likely to pass those costs on to its workforce as a whole, without treating employees differently depending on where they reside.

If the health care system becomes Balkanized, many states are likely to engage in a very unhealthy competition with each other, as they seek to revise their health care laws in order to attract or retain business in the state. Thus, businesses will be encouraged to leave one state for another where health care coverage or costs are lower for reasons that may have nothing to do with quality of care. Whatever the merits of such "bidding wars" in other contexts, this is no way to fashion a sensible health care policy.

Costs will be increased not only by the inconsistency of state legislation but also by the content of that legislation. For example, if ERISA preemption is waived, states will be free to subject self-insured health plans to "mandated benefit" legislation that now applies only to insured plans under state insurance laws. There are now over 900 mandated benefit laws on the books.[6/] These laws vary widely from state to state; many of the laws appear to be designed to protect certain groups of health care providers rather than the health of the citizens of the state.

Mandated benefit laws prevent employers from providing uniform benefits on a nationwide basis, force employers to provide (and employees to receive) benefits that they do not desire in lieu of the benefits they prefer, and increase the number of employers that cannot afford to sponsor health care plans for employees and their dependents.

For example, S.3180 allows each state to (1) impose taxes and other fees on employee benefit plans, (2) mandate a standard benefit package, (3) establish a common administrative procedure, an electronic claims processing procedure, a data collection mechanism, and a utilization review, quality assurance, and medical outcomes mechanism, and (4) implement a negotiated health care provider reimbursement rate system.

Under S.3180, all of these requirements can vary from state to state, thereby entangling multi-state health plans in a costly, complex, and inefficient morass of conflicting state requirements.

Although S.3180 includes a limited exception for self-insured plans, the exception fails to provide meaningful relief for multi-state employers. The exception applies only to the state's standard benefit package. The exception does not apply to any of the other state mandates that the bill allows, all of which can vary from state to state. In addition, the exception applies only if a new federal commission determines that the employer's per-employee contribution meets a specified standard with the state.

The unfortunate experience we all had under Section 89 of the Tax Reform Act of 1986, prior to its repeal, teaches us that such determinations are extraordinarily difficult to make. Moreover, given the thousands of self insured plans in the nation, it is clearly impractical to saddle a federal agency with the task of making individual determinations for each self-insured plan.

6/ Blue Cross & Blue Shield Ass'n, Issue Review (Feb. 1992).

ALTHOUGH STATE TAXATION OF EMPLOYEE BENEFIT PLANS MIGHT BE POLITICALLY EXPEDIENT, IT IS INEQUITABLE.

Many of the proposals to weaken ERISA preemption, including S.3180, are designed to permit the states to finance health care reform by taxing health plans.

Taxing health plans in order to finance the cost of health care reform is highly inequitable. Employers that voluntarily provide health care coverage, and the employees who participate their employers' plans, already pay more than their fair share of the cost of health care. Employer-sponsored plans generally cover not only the employer's own employees, but also the employees' spouses, including employed spouses whose employers do not provide health care. In addition, employer-sponsored plans must bear health care costs that have been inflated as a result of cost-shifting from Medicare and Medicaid and the cost of uncompensated care.

It is therefore highly inequitable to target employer-sponsored plans as a revenue source to finance reform of the health care system, particularly when the tax on employer plans is intended to subsidize other employers who do not offer health care coverage. A tax on employer-sponsored plans punishes those who already bear a disproportionate share of the cost of providing health care.

States appear to have targeted employer-sponsored plans as a revenue source, not because taxing health plans is equitable or appropriate, but because the states have not mustered the political will to finance health care reform through equitable, broad-based taxes. The states' unwillingness to finance health care reform through broad-based taxes does not justify imposing inequitable taxes on those who already bear a disproportionate share of the cost of health care.

The problems created by state taxes on health care are not limited to employers and employees within the borders of the taxing state. There inevitably will be disputes between states regarding the scope of a state's taxing power. Just a week ago, for example, *The Wall Street Journal* reported that Minnesota, which has levied a two percent tax on hospital revenue in order to finance its new health-care system, will seek to impose its new tax on out-of-state hospitals (including Canadian hospitals) that treat 20 or more Minnesotans a year. Not surprisingly, according to the *Journal*, Minnesota's attempt to tax out-of-state hospitals has provoked "feverish protests" from neighboring states.[2/]

This recent experience in Minnesota illustrates the potential for "Balkan" conflicts among states -- both conflicts between the regulatory and taxing authorities of various states and conflicts that stem from the ability of individuals and businesses to

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[2/] *The Wall Street Journal* at p. 1 (Sept. 2, 1992).

move from one state to another in response to differences between state health care systems. It is difficult to believe that a rational health care policy will emerge from these conflicts.

ERISA DOES NOT PREVENT THE STATES FROM EXPANDING HEALTH CARE COVERAGE.

The states can expand health care coverage without amending ERISA. The states can enact legislation that expands health care coverage, or access to coverage, or that raises revenue to finance the cost of health care, without amending ERISA. The states have a variety of measures at their disposal to solve these problems. ERISA merely prevents the states from taxing and regulating employer-sponsored plans: the plans that already provide coverage to employees and their dependents.

Thus, ERISA does not stand in the way of any state that wishes to deal with health care as it would deal with any other social welfare issue. The problem is the states' unwillingness to address health care coverage and access issues without interfering with one aspect of the health care system that actually works and provides health coverage to approximately 150 million citizens: employer-sponsored health plans.

WEAKENING ERISA PREEMPTION WILL CREATE NEW BARRIERS TO NATIONAL HEALTH CARE REFORM.

Proposals to weaken ERISA preemption and to encourage the states to regulate the health care system pose two significant dangers.

First, state legislation is likely to act as a smoke screen that diverts attention from the need for federal legislation that addresses the nation's health care problems on a uniform, nationwide basis. If Congress weakens ERISA preemption and allows the states to regulate health plans, attention will be deflected from the need for national reform, and the momentum for national health care reform that has been building in recent years will dissipate.

Second, once the states establish their own regulatory regimes -- and invest considerable time and effort in implementing them -- there is likely to be strong resistance to proposals for a federal regime that will supplant state regulation. New state laws, and the state agencies that administer them, will create new constituencies that will have vested interests in preserving the status quo and that will resist federal efforts to reform the health care system on a uniform nationwide basis.

Ceding to the states the authority to regulate the health care system is thus likely to postpone federal action for the foreseeable future. State legislation will become a part of the problem, not the solution.

STATE REGULATION IS NOT THE ONLY ALTERNATIVE. CONGRESS SHOULD NOT ABDICATE ITS RESPONSIBILITY.

Sponsors of proposals to weaken ERISA preemption have argued that state regulation is the only alternative to the alleged "gridlock" that prevents federal reform of the health care system. This is simply not correct.

We are gratified by the serious and thoughtful efforts by many members of Congress, including many members of this Committee, and by the Administration to address the nation's health care problems. The fact that there is not yet a consensus on how to solve these problems reflects the difficulty and magnitude of the problems, not the existence of a "gridlock."

Progress is being made, however. The positions of various proponents of health care reform are coming closer together, and many now acknowledge the need for a uniform national framework. This is not the time for Congress to throw in the towel. Congress should not abdicate its responsibility to address the nation's health care problems. To the contrary, Congress should now be renewing, not abandoning, its efforts to reform the nation's health care system.

Mr. Chairman, this completes my prepared statement. I want to thank you and the other members of the Committee for the opportunity to appear before you today. I will be happy to answer any questions that you or the other members of the Committee might have.

THE ERISA INDUSTRY COMMITTEE

Interim Policy Statement[1] on Health Care System Reform

I. Introduction.

Members of The ERISA Industry Committee (***ERIC***), all major employers[2], directly pay for the health care of over 25 million employees, retirees and dependents. Thus, they have been in the forefront of efforts to reduce health care costs while providing access to quality health care.

Large employers have a strong interest in providing voluntary employment-based health care coverage to employees and their dependents in order to foster a healthy and productive work force, respond to workers' concerns about economic security and affordable basic health care, and offer health care coverage as part of a competitive compensation package to attract and retain valued workers. The health care coverage arrangements of large employers represent an investment in quality and productivity and are tailored to the specific needs of each employer and its work force. Thus, in order to preserve a dynamic system, many large employers believe they should continue to have the opportunity to be the principal source of health care coverage for employees and their dependents.

ERIC members are deeply concerned about the rapidly increasing cost of providing health care coverage to employees and their families. Total health care expenditures have risen from 6 percent of GNP in 1965 to 12 percent in 1990. The Health Care Financing Administration has estimated that aggregate health care expenditures, which were about $250 billion in 1980 and $600 billion in 1990, will increase to more than $1 trillion by 1995 and $1.6 trillion by 2000. In the last decade alone, employers' health care expenditures have risen from less than one-third of corporate pre-tax profits to nearly one-half of pre-tax profits. Large employers are concerned that neither they nor anyone else will be able to continue to provide the level of coverage and quality of care upon which they

1 This Interim Policy Statement on Health Care System Reform is a working document, subject to further revision. It was approved as an interim statement of ***ERIC*** policy by the Board of Directors on December 12, 1991.

2 ***ERIC's*** membership is limited to companies that employ at least 10,000 U.S. employees and provide comprehensive retirement, health and other welfare benefits.

and their employees have relied unless costs are quickly and decisively brought under control.

A broad consensus is emerging among large and small employers, consumers and even health care providers that significant changes in the current health care system are needed; but there is no consensus on what comprehensive reforms should be pursued. ***ERIC*** believes it is important to establish a policy position on health care system reform that reflects a major employer viewpoint. This Interim Policy Statement is intended to assure that the interests of major employers will be articulated and forcefully represented in the health care system reform policy debate.

This Interim Policy Statement remains a working document and is subject to further revision. ***ERIC*** also recognizes that, in its present form, this Interim Policy Statement does not encompass every element of the current debate. Instead, the interim policy statement focuses on issues relating to coverage of primary and acute care. ***ERIC*** may incorporate principles and strategies regarding other elements in the future.

II. Background.

The U.S. health care system has serious problems. Each year billions of dollars in health care expenditures are wasted on inappropriate or poor quality health care. The rapidly escalating cost of health care has forced both private and public payers to reduce coverage, shift costs to other payers, or require individuals to assume a greater share of total costs. Cost shifting among payers has exacerbated the increasing cost of health care for most payers, which has further eroded coverage. As a result, millions of Americans lack reasonable access to basic health care or lack the financial resources to obtain care, except through inefficient settings such as hospital emergency rooms or through already overburdened public health clinics.

The traditional buyer-seller relationship between consumers (patients) and sellers (health care providers) is lacking in the health care market place. Instead, patients are frequently insulated from the direct full cost of care by their health care coverage, with a substantial portion of total reimbursements for care coming from third-party payers (employers, insurers or government). Moreover, health care is consumed under conditions that include severe illness, pain and suffering, and the threat of death. In these circumstances it is understandable that many consumers may not be in a position to seek the most efficient and cost effective health care providers. In addition, third-party payers often lack reliable information about price and quality to direct consumers toward the most efficient and cost effective health care providers. Thus, America suffers from a perverse health care market in which the entry of additional health care providers does not reduce price through increased competition (as in normal markets), but increases the price and volume of health care consumed.

The need for health care reform is a national problem, requiring national solutions. Both the market for health care and the means for financing it are immersed in interstate commerce. Since the federal government manages, provides or regulates a substantial portion of our current health care system, compatibility of private and public elements of the health care system can be assured only by the development of a comprehensive national policy.

There have been many proposals for health care system reform. They range from national health insurance schemes to narrowly based risk pools for the poor and near poor. Up until now, few proposals have given adequate weight to the need to address cost and quality as well as access. As long as health care costs continue to rise at current rates, and high volume and high intensity health care continue to serve as a surrogate for quality care, coverage will become increasingly unaffordable to public, private and individual payers.

III. General Principles for Health Care System Reform.

ERIC believes that health care system reform should be based on the following principles:

- A public-private partnership encompassing payers, providers and patients to design and implement reform;
- A comprehensive strategy for making the health care system coherent, efficient and cost effective;
- An opportunity for employers to voluntarily continue to be the primary source of health care coverage for their own employees and their employees' dependents; and
- Federal leadership in establishing a national health care policy.

ERIC believes that without such principles of reform, reasonable access to affordable health care will continue to be unavailable to those who lack coverage and employers that already provide coverage will continue to bear a disproportionate share of the costs of financing health care.

IV. Strategies for Implementation of the General Principles.

In order to implement the general principles stated above, the following health care system reform strategies should be developed:

First, the process of providing health care and the expected outcome of treatment must be defined to improve quality and to eliminate inappropriate care and unjustified variations in practice patterns;

Second, the perverse health care market place must be restructured by replacing current incentives that reward excessive volume and intensity of health care with incentives that reward high quality and efficiency;

Third, responsibility for financing health care must fall equitably among payers in order to prevent inefficient and inequitable cost shifting among the payers; and

Fourth, health care resources must be allocated more efficiently to provide adequate distribution of resources throughout the entire health care system.

ERIC recognizes that any reform has the potential to produce both winners and losers. Therefore, comprehensive reform of the health care system must also provide for an orderly transition so that inevitable dislocations resulting from reform will be minimized. ***ERIC*** will support incremental reforms to the extent that they contribute to a coherent national health care system reform strategy.

A. Defining the process of providing health care and the expected outcome of treatment.

Successful health care system reform will improve the quality and efficiency of health care, reduce expenditures for inappropriate care, and eliminate unjustified variations in medical practice patterns. In order to reduce wasteful health care expenditures, providers, patients and third-party payers must work together to assure that expenditures for health care coverage are limited to care that is:

- medically necessary;
- appropriate in treatment and setting;
- clinically proven effective in extending life or improving quality of life; and

- delivered through systems in which health care providers are accountable for the quality and efficiency of care.

A health practice standards body, including representatives of providers, payers and consumers, should be created to provide leadership in public-private partnerships to improve the quality and efficiency of care throughout the health care system.

The health care "product" (i.e., the process of providing health care and the expected outcome of such treatment) must be subject to defined quality standards that are measurable and to the expectation that the quality of hea'th care will improve over time. This means implementing:

- standards of medical appropriateness that are integrated into the design of health care delivery systems;
- quality measurement data systems that allow payers to identify and reward high quality health care;
- health care management systems that are accountable for the quality and efficiency of health care delivery; and
- appropriate and effective systems to detect medical malpractice and fraud and discipline offenders.

B. Restructuring the perverse health care market place.

Successful health care system reform will replace the perverse, dysfunctional portions of the health care market place that reward excessive volume and intensity of health care with a market place in which health care providers operate and compete on the basis of quality and efficiency. Health care providers, patients and third-party payers must work together to foster a market place that maximizes the value of the health care being financed by establishing mechanisms for health care financing that include:

- the means by which providers as well as patients and third-party payers share the financial risk of the failure to contain costs;
- reimbursement methods (e.g., prospective payment or alternatives), payment rates (e.g., fee schedules or alternatives) and/or volume controls that reduce the incentives causing unnecessary consumption under traditional indemnity coverage ;

3 Traditional indemnity coverage is typically based on fee-for-service reimbursement of reasonable and customary charges as well as unrestricted choice of physicians and hospitals by the covered individual.

- adjustments to baseline payments that financially reward high quality health care providers and penalize low quality providers; and
- incentives for organizing health care delivery systems that are not based on traditional indemnity financing.

Encouraging health care providers to compete on the basis of the quality and efficiency of care requires the implementation of:

- integrated health care delivery systems (e.g., HMOs, managed care networks and other alternatives) that provide other than traditional indemnity financing of health care, developed in a manner that promotes and manages competition among health care delivery systems;
- standardized data systems to provide payers, consumers and providers with adequate information about health care quality, cost and utilization;
- standardized claims forms and claims procedures to reduce administrative overhead for both payers and providers;
- compatible private and public payment systems to reduce cost shifting among payers; and
- a rational system to identify and compensate injuries that result from medical malpractice.

In addition to implementing these strategies, the private group health insurance market must be improved by:

- eliminating costly state benefit mandates, premium taxes and anti-managed care laws that artificially increase the cost of health care coverage;
- reducing disproportionately high administrative, marketing and overhead costs in the small group market; and
- reforming insurance rating and underwriting practices.

C. Sharing equitably the responsibility for financing health care.

Successful health care system reform will reduce cost shifting that results when providers charge individuals with health care coverage higher prices to offset the cost to the provider of uncompensated care (i.e., care provided to persons who lack insurance or personal resources to pay for it) and undercompensated care (i.e., care that is reimbursed by government programs, like Medicare or Medicaid, at rates that do not cover the provider's actual costs). This form of cost shifting is inefficient because it finances health care by imposing an indirect "tax" on both covered workers and their employers that is hidden, thereby

escaping scrutiny and justification. This tax is inequitable as well because it is imposed on employers and employees already paying for health care coverage. In order to make health care financing more efficient and assure the equitable assumption of responsibility for financing the costs of care:

- all individuals should receive basic health care that is financed directly by either private or public health care coverage, and
- both private and public coverage, in combination with out-of-pocket expenditures, should fully compensate health care providers for reasonable health care costs.

Before direct financing of health care can be provided for all individuals, however, certain conditions must be met to assure that such financing is economically sustainable, including:

- effective system-wide quality measures and cost containment measures must already be in place;
- "basic health care" must be defined on the basis of the cost effectiveness of care; and
- individuals must be guaranteed access to "basic health care" only.

Improving the efficiency and equity of health care financing requires the implementation of:

- public programs that cover all of the poor and that fully compensate providers for the reasonable costs of care; and
- appropriate government intervention in the marketplace to ensure that all non-poor individuals have group coverage from a nonemployment-based source, if not from an employment-based source.

Where individuals and their employers together lack sufficient resources to finance adequate health care coverage, any necessary government subsidies should be financed from general revenues rather than direct or indirect taxes on employers that already provide coverage. In addition, Medicare should remain the primary payer of the cost of health care coverage for the elderly.

ERIC believes that, regardless of the specific mechanism used to ensure direct financing of health care, employers should have the opportunity to voluntarily continue to be the primary source of health care coverage for their employees and their employees' dependents. Providing employers such opportunity requires that:

- the current tax deduction for employer-provided health care coverage is preserved; and

- employers are not restricted in their ability to design flexible employee cost sharing arrangements, not required to provide specific benefits in excess of "basic health care," and not subjected to open-ended financial liability to pay for care.

In addition, *ERIC* believes that federal preemption of conflicting state activity is necessary to ensure compatibility of the delivery and financing systems used throughout the country. This federal role should be limited, however, and payers and providers should be free from micromanagement by federal government bureaucracies.

D. Allocating health care resources more efficiently.

Successful health care system reform will eliminate the inefficient distribution of resources within the health care system. Health care providers, payers and consumers must work together to establish a process for determining system-wide expenditures and effectively allocating resources within the system. In order to improve efficiency and eliminate excess capacity, a process must be initiated that, among other functions, provides for:

- coordinated technology assessment and dissemination;

- standardized cost accounting by health care providers and third-party payers; and

- cost effective capital investment.

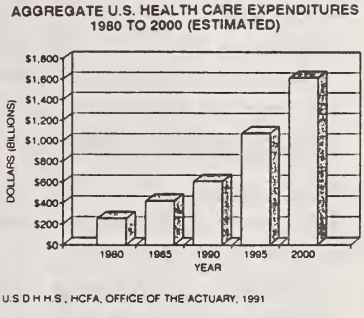
V. Discussion of the General Principles and the Strategies for Their Implementation.

This Interim Policy Statement articulates general principles, as well as broad strategies for implementing those principles. It does not put forward a specific proposal. Health care quality, costs and access implicitly are examined in the statement, but not according to the familiar "quality-cost-access" framework. Specifically, the four "health care reform strategies" articulated in this document are hierarchical, each building on the one that precedes it. In this way, the four strategies move from a consideration of delivery of health care to allocation of resources.

A. General principles for health care system reform.

Overview: There are a plethora of proposals being offered by legislators, interest groups and commentators to reform the health care system. While there is general consensus that current conditions — including increasing health care costs, inconsistent quality and diminishing access to care — cannot be sustained in the long term, there is little consensus about the appropriate public policy response. The lack of consensus may be due, in part, to the emphasis frequently placed on specific concerns, such as "access to health care" or "cost containment." This emphasis tends to polarize the political debate. Constructive debate occurs where there is a balanced discussion of health care quality, cost and access.

Chart 1



Issue: whether the principles should embrace an incremental approach or a comprehensive approach to health care system reform. There are at least two kinds of incremental approaches to reform. First, in the absence of consensus for broad-based reform, some policy makers favor enactment of piecemeal reforms now. Medical malpractice reform and private small-group insurance reform are two areas often suggested. This incrementalism is based more on political pragmatism than policy objectives, and proponents may still believe that comprehensive reform is needed in the long term. Second, incrementalism as a specific policy objective is premised on a belief that the current health care system is fundamentally sound, but specific segments of the system need to be refined. Proponents assert that both approaches offer the advantage of minimal disruption of the health care system. Critics assert such "tinkering" will produce only short-term gains and reject such approaches as ineffectual in the long term.

There are at least three kinds of comprehensive approaches to health care system reform. Some policy makers have put forward proposals to build on the current mixed public-private health care system, restructuring it to address weaknesses in the way health care markets operate. In this view, a coordinated strategy of related reforms is necessary to achieve any lasting improvements in health care cost, quality and access. Other policy makers propose replacing the current mixed public-private system with either a single national health insurance program or a system where each state implements a health insurance program within federal guidelines.

Each of the mixed public-private and purely public approaches are premised on the belief that the current health care system, as it has evolved during this century, has serious structural flaws that cannot be addressed effectively by piecemeal reforms. Proponents assert that these comprehensive approaches offer the advantage of making the health care system more coherent, efficient and cost effective. Critics assert that comprehensive reforms will not be implemented without unwarranted government regulation. They reject such approaches as intrusive and disruptive to the health care system, the economy and personal choice.

After considering the evidence of the extent of dysfunction in the present health care system, ***ERIC*** reached a preliminary conclusion that the weaknesses in the current system are structural, not superficial. Therefore, reform would require a coordinated, comprehensive public policy. The Interim Policy Statement calls for such reform to be implemented through four related strategies, to build upon the mixed public-private health care system and make it more coherent, efficient and cost effective. Several ***ERIC*** members also noted, however, that certain incremental reforms could have value in the absence of consensus on comprehensive reform. Thus, ***ERIC*** supports incremental reforms that are consistent with or contribute to the development of comprehensive reform strategies.

The general principles refer to the need for federal leadership in developing a national health care policy. This element of the interim policy statement represents an assertion that the health care system can only become coherent, efficient and cost effective if reform is carried out pursuant to a comprehensive federal policy rather than diverse and independent state action. The absence of a coherent national policy, encouragement of state experimentation, or reliance on other piecemeal incremental approaches could further fragment the health care system and increase costs. This does not necessarily mean that states should have no role in planning, financing or administering a restructured health care system, only that such state role be subordinated to a comprehensive federal strategy.

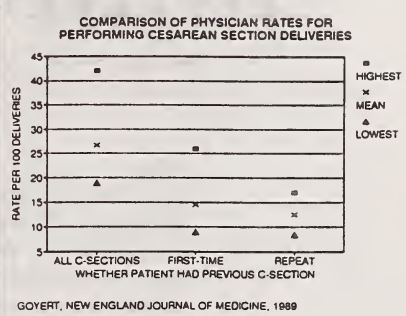
B. Strategies for implementation of the general principles.

1. Defining the process of providing health care and the expected outcome of treatment.

Overview: Individuals seek health care to treat illness and restore good health. We each measure the success or failure of the health care we receive by the personal outcome it produces. As a society, we have not articulated a clear consensus on the goals of the health care system as a whole, on the results we expect the system to achieve or on the most efficient means to achieve those goals. To use a manufacturing analogy, we have not effectively defined product specifications, systematically measured the quality of what we produce, or consistently improved the production process. This lack of critical analysis of the purpose and performance of the health care system appears to be a root cause of the system's weakness and dysfunction.

Issue: whether to address the quality and appropriateness of health care in the statement. Concepts such as "quality" are difficult to define and articulate. This issue can not be ignored, however, since consideration of other issues invariably raises questions about how to ensure that patients and third-party payers receive value in return for their health care expenditures.

Chart 2



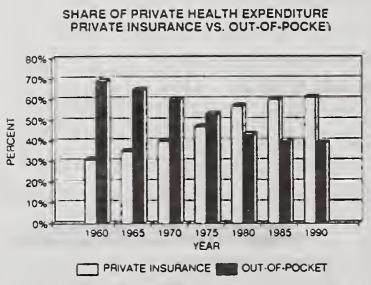
GOYERT, NEW ENGLAND JOURNAL OF MEDICINE, 1989

ERIC considered and rejected a concept of "quality" frequently expressed by patients: that "quality" is proportionate to the cost, technical sophistication, and intensity of treatment. More "high-tech" care or more intense care may be more expensive care, but it does not necessarily produce a better medical outcome. Members were further troubled by large differences in medical practice patterns and the proportion of common medical procedures performed that research has found to be unnecessary — as much as 20 to 30 percent for certain high-volume procedures. Therefore, the Interim Policy Statement asserts that the purpose of health care coverage is to finance health care where quality is defined in terms of care that is medically necessary, appropriate and effective.

Issue: whether current techniques, such as utilization review, are sufficient to ensure the quality and efficiency of health care delivery. Many employers now rely on increasingly sophisticated utilization review techniques to monitor health care reimbursements. Health care providers often view utilization review in an adversarial manner, however, perceiving such techniques as a means of denying reimbursement rather than as a true quality assurance mechanism.

ERIC reached a preliminary conclusion that consumers and payers could do more to provide incentives to the health care community to improve the quality of care, including holding health care providers accountable for the efficiency of care they provide. Improving quality and efficiency is not limited to reducing malpractice, but includes reducing unnecessary care and eliminating unjustified disparities in the frequency with which physicians in different communities perform certain medical procedures. Therefore, the Interim Policy Statement calls upon the medical community to work with payers to articulate a consensus on standards of medical appropriateness. It also calls for the development of objective performance measures to be used by payers to monitor quality over time, not just to review utilization on a case-by-case basis.

2. Restructuring the perverse health care market place.



LAZENBY & LETSCH, HEALTH CARE FINANCING REVIEW, WINTER 1990

Chart 3

Overview: Many factors distort economic behavior in the health care market place. Several are discussed in II. Background, above. As noted there, the health care market is not a consumer-driven market in the classical sense. Commentators have observed that since health care providers control diagnosis and treatment, the perceived role of a physician as a patient advocate encourages the use of any treatment that might be beneficial, even when the odds for improvement are small relative to the cost to patients and third-party payers of such treatment.

In addition, the health care market place is in fact at least two markets: the Medicare/Medicaid market place, which is subject to government enforced pricing mechanisms, and the private employment-based market place. Since Medicare, Medicaid and other government health care programs account for about 40 percent of aggregate national health care expenditures, the mere existence of these government health care programs distorts behavior in the private market place.

While there has been significant recent growth of health maintenance organizations (HMOs), provider networks and managed care, the U.S. health care system remains based primarily on indemnity coverage rather than coordinated or organized health ca. delivery systems. Under traditional indemnity financing, patients generally have unlimited choice among primary care physicians and are free to refer themselves to medical specialists. Health care providers typically are compensated for each procedure they perform, regardless of the number, effectiveness or outcome of the treatments. Within this indemnity framework, payers have few means to enforce fiscal discipline other than through utilization review and selective contracting. Further, with so many health care

providers acting independently from one another, there is considerable administrative overhead in addition to inconsistency in medical practice style. As a result, average health care costs in employer-sponsored indemnity plans are rising fastest among all types of health care coverage.

Issue: whether any public policy effort should be made to improve the long-term economic viability of indemnity coverage. There continues to be a strong preference among many patients for indemnity coverage despite continuing cost escalation. Moreover, the fact that such a small proportion of Medicare enrollment is in organized health care delivery systems (including managed care) that provide coordinated care has helped to entrench indemnity coverage as the "mainstream" form of health care financing in our health care system. Commentators have suggested that this cultural bias in favor of indemnity coverage could make it politically and socially impossible to allow such coverage to be priced out of the market entirely. If this view is correct, a substantial portion of the health care system will continue to be based on indemnity coverage for the foreseeable future. Therefore, ***ERIC*** concluded that the health care market place could not be restructured effectively without taking into account the weaknesses of prevailing fee-for-service indemnity health care financing.

Issue: whether effective market forces could be developed to contain costs sufficiently, especially in traditional indemnity arrangements, without resorting to unreasonable government regulatory intervention. Many employers have already explored two general approaches in response to the inherently weak cost discipline of traditional indemnity coverage. The first approach is restricting choice of providers, by encouraging or requiring employees and dependents to move into managed care networks or HMOs. The second approach is increasing the share of total costs borne by employees. Employers have encountered varying degrees of resistance to each approach.

ERIC did not limit its consideration to approaches already being pursued by employers, but also reviewed a range of approaches, including the following:

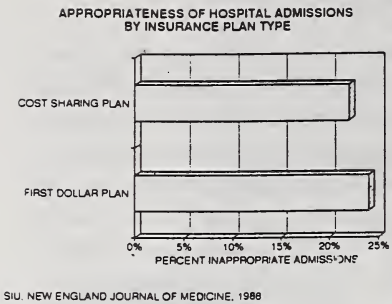
- Shifting costs to employees and dependents to make them more cost-conscious:

  Many economists assert that the provision of health care coverage by a third party encourages individuals to consume more health care less wisely than they would in the absence of such coverage. Therefore, some commentators have suggested that employees and dependents share a greater proportion of health care costs to make them more conscious of cost and quality when seeking health care.

  Research suggests that increased cost sharing (in the form of higher deductibles and copayments, for example) can reduce health care utilization without resulting in a decline in individuals' health status, except possibly

among low-income individuals and families. This research has led some commentators to conclude that increased cost sharing can be an effective tool to slow utilization as part of a strategy to contain aggregate health care expenditures.

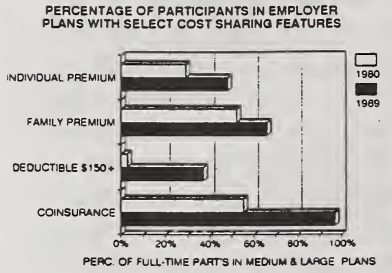
Chart 4



SIU, NEW ENGLAND JOURNAL OF MEDICINE, 1986

In response, critics of increased cost sharing note that subsequent research produced results that support a different conclusion. For example, studies of hospital admissions found that while increased cost sharing in health coverage lowered hospital admission rates, the proportion of admissions that were found to be inappropriate, as well as the proportion of hospital days per admission that were inappropriate, remained about the same as under coverage without cost sharing. This suggests that cost sharing was likely to discourage some individuals from seeking needed health care while discouraging others from consuming unnecessary or inappropriate care. It seems certain that additional research is called for to determine more precisely the way increased cost sharing alters behavior with respect to the consumption of health care and the long-term impact of such behavioral changes on a person's health.

Chart 5



U.S D.O.L., BLS, EMPLOYEE BENEFITS IN MEDIUM AND LARGE FIRMS, 1980, 1989

A significantly larger proportion of employers — both large and small — now include cost sharing features in their health care plans compared with a decade ago. While such cost sharing helped moderate utilization, health care expenditures continue to grow at unacceptable rates. Based on this experience, ***ERIC*** reached a preliminary conclusion that it may be appropriate for some employees to assume a greater portion of the economic burden of financing their health care coverage, although increased cost sharing alone is unlikely to be a sufficient cost containment strategy in the long term.

- Collecting and disseminating better data about cost and quality to make health care markets more efficient:

  When payers and patients assume responsibility to act like consumers and attempt to select providers on the basis of quality and price, the quantity and reliability of relevant information currently available in the market place limits their ability to make such decisions intelligently. A few states and the Department of Health and Human Services have begun to organize the col-

lection and publication of rudimentary health care data. Continued development of such data systems is essential to improve the quality, efficiency and cost effectiveness of the health care system, and should be actively encouraged.

Reliance on improved information alone to contain health care costs presents several risks, however. For example, critics assert that full implementation of such data systems throughout the country, even under the best circumstances, could be many years away. If this view is correct, costs could continue to rise unabated until implementation is complete. Even when such systems are in place, consumers and third-party payers will need to be educated to ensure that the information will be used consistently and effectively.

- Creating incentives for expanded use of managed care and other organized health care delivery systems:

  Expanded use of managed care and other organized health care delivery systems could fundamentally alter medical practice styles compared with those that prevail under the patchwork quilt delivery system financed by traditional indemnity coverage. HMOs, managed care networks and similar arrangements incorporate a management structure that potentially can be held accountable for the quality, cost and efficiency of all aspects of a patient's care, not just separately billed procedures. They also can share the financial risk of cost containment through special contractual arrangements with employers that are generally precluded by the nature of traditional indemnity coverage. Such entities, whether organized by providers, insurers or employers themselves, could have an important role in shaping the health care system.

  For several reasons, fully developed organized health care delivery systems currently represent a minority of the health care system as a whole. Some proponents of coordinated care are pessimistic: our society's purported cultural bias in favor of freedom of choice of health care providers is arguably so pervasive that managed care and organized delivery systems may never fully penetrate the market place. In addition, critics assert that such techniques have yet to demonstrate their long-term ability to control costs while maintaining the quality of care. If these views are correct, reliance on incentives for increased use of managed care and organized delivery systems alone is likely to have limited short-term effectiveness.

  Unless there is a groundswell of support for these alternatives to traditional indemnity coverage, perhaps fueled by a crisis of increasing costs and declining coverage, the long-term impact of this approach on the health care system is uncertain. There is room for improvement in the state-of-the-art, because many managed care techniques are in their infancy. There

is also considerable promise. Therefore, continued development of such organized delivery systems and managed care techniques is essential to improve the quality, efficiency and cost effectiveness of the health care system, and should be actively encouraged.

- Creating community-wide mechanisms for payers and providers to negotiate prices and volume targets for indemnity coverage:

  Another approach to attack the structural weaknesses of the indemnity-dominated market is to encourage group negotiation of health care purchasing rather than individual negotiation. For example, one way this approach might be pursued is through community-based mechanisms for payer groups and provider groups to negotiate price and volume targets for indemnity coverage.

  Proponents assert that this negotiated approach has the advantage of allowing countervailing market forces to determine the cost of care within a more structured framework than the current indemnity system. Within this framework, each participating payer shares the benefit of cost containment efforts, not just those payers big enough to command sufficient market power to negotiate discounts. Within this framework, reimbursement mechanisms based on single package prices for treating an episode of illness also could be negotiated to replace reimbursement on a per-procedure basis. Further, differentially higher payments could be negotiated for physicians and hospitals that are identified as providing the highest quality care.

  Proponents suggest that negotiating price, volume and reimbursement methods for all indemnity coverage could result in a positive interaction with the development of managed care and organized delivery systems. Managed care networks and organized delivery systems must offer competitive compensation to attract high-quality professionals. As long as traditional indemnity coverage dominates an unstructured market place, imposing few limits on the ability of health care providers to maximize income at the expense of the affordability of care, there is arguably a natural limit to the cost savings these alternative delivery systems can achieve and still attract quality professionals. Some commentators assert that HMOs and managed care networks have already resorted to "shadow-pricing" mainstream indemnity coverage. From this perspective, imposing price and volume discipline on indemnity coverage might strengthen the bargaining position of managed care and organized delivery systems when they negotiate compensation with their health care professionals.

  This approach also has several shortcomings. Critics assert that purely voluntary efforts to organize such negotiations on a broad basis may not be feasible. Employers may be reluctant to call for government intervention to ensure an effective, enforceable negotiation process. Consistency of imple-

mentation across communities, states and regions could be a particular problem. Further, full implementation on a national scale could take many years to complete. Concerns have also been expressed that there would not be sufficient flexibility in reimbursement methods, payment rates and volume controls to provide incentives for innovation and high quality. It would be easier to structure a "one-price-fits-all" system than to advance the state-of-the-art in the relationship among financing methods, supply and demand, and market determination of the price of health care.

- Setting reimbursement rates by government regulation:

  Another alternative would eliminate market forces altogether, substituting uniform reimbursement methods, payment rates and volume targets that are determined by government regulation. In effect, a cost containment mechanism similar to Medicare could be expanded to the health care system as a whole. Proponents assert the primary advantage of replacing market mechanisms for determining price and volume with government regulation is the relative certainty and predictability it might eventually achieve. Proponents also argue that it would force a reduction in administrative costs that could not be matched by other nongovernmental approaches. ***ERIC*** members are concerned about the detrimental consequences of a fully regulated cost containment system, however. For example, critics assert that this approach would have a detrimental long-term impact on innovation and the quality of care, and may lead to government setting limitations on the availability of care.

After considering the advantages and disadvantages of each of the five general approaches discussed above, ***ERIC*** concluded that no single approach currently on the table appears likely to address all of the primary weaknesses of the present health care market place. There is general agreement on many elements, such as the need for more price and quality information in the market place. There also was general agreement on the need to eliminate state laws mandating particular benerits, imposing taxes on health insurance premiums or restricting the use of utilization review and managed care since such state laws appear to have inflated the cost of coverage and eroded access to care. Because there is no broad consensus that the approaches on the table will be effective, the Interim Policy Statement outlines the commonly agreed-upon actions that must be taken to ensure that market forces operate in a more structured environment that promotes and manages competition in the health care market place on the basis of quality and efficiency.

3. Sharing equitably the responsibility for financing health care.

Overview: Access to health care is frequently debated in terms of whether or not all Americans are entitled as a matter of right to health care coverage. Even

if health care coverage is not a right, however, providing a means to directly finance coverage for each individual may make sense for other policy reasons.

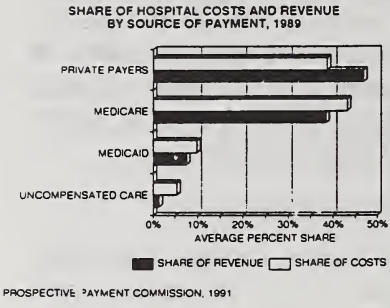


Chart 6

For example, access issues are difficult to separate from financing issues. Persons without health care coverage do not always lack access to health care. The lack of coverage may cause them to put off seeking care until they are too sick to put it off any longer, and then to seek care in a hospital emergency room rather than from a primary care physician. In this case, health care is provided but it is more costly and inefficient than it would have been if the individual had coverage. Someone pays for this care, even if the patient does not.

Some commentators assert that since individuals with coverage and their third-party payers now indirectly pay for uncompensated care in the form of higher prices, it would be more efficient and cost effective to provide direct financing of health care for each American. Altruism aside, this view suggests that direct financing for each individual is good fiscal policy.

This does not mean that providing each individual with direct financing for health care itself would result in a net reduction in aggregate health care expenditures. Persons who lack coverage tend to use less health care services than persons with coverage, so expanding direct financing would probably increase utilization. If increased utilization was sufficient to offset savings from decreased reliance on cost-ineffective health care settings like hospital emergency rooms to provide uncompensated care, aggregate health care expenditures would increase. Eliminating the necessity for health care providers to shift costs among payers to make up for uncompensated care makes health care financing and planning more straightforward, however. In turn, this would make cost containment strategies more effective. In addition, a general improvement in the health status of formerly uninsured persons could result, with positive economic and social consequences such as improvements in work force productivity.

Thus, ***ERIC*** does not seriously question, in principle, the desirability of providing direct financing of health care coverage for each individual. Proponents argue that the health care system cannot be made rational and health care costs cannot be contained effectively without direct financing of health care for all Americans in order to eliminate cost shifting among payers due to uncompensated and undercompensated care. The difficulty is achieving this goal without excessive government intervention.

Issue: whether direct financing of health care for each individual can be accomplished without abandoning reliance on a mixed public-private health care system. Discussion began with a consideration of the probability that direct financing for each individual could be achieved solely by means of expanded public programs and incentives for the voluntary expansion of private coverage. ***ERIC*** considered the economic realities of small businesses and the health care system. Members concluded that incentives for a voluntary expansion of coverage are unlikely to achieve this direct financing goal.

During the last decade, several proposals were put forward to require employers to provide specific minimum health care coverage directly to their employees through an employer-sponsor d plan and that employees accept such coverage (e.g., the Kennedy mandated benefits bills). In combination with expansion of government programs for persons not connected to the work force, this approach could achieve direct financing goals. Recent proposals (e.g., the Pepper Commission, the Senate Democratic Leadership bill, and others) give employers a choice between providing coverage directly through an employer-sponsored plan or financing it by paying a payroll tax to fund coverage under a public insurance pool. Individuals without employment-based coverage would be required to participate in the public plan. This approach is frequently called "pay-or-play."

Proponents assert that both of these employment-based approaches have the advantage of achieving direct financing by building on the currently voluntary employment-based system. The major functional difference between earlier proposals and pay-or-play is who is responsible for organizing health care coverage and making it available to employees. Under pay-or-play, employers are required to help finance health care coverage, but they have a choice between administering an employer-sponsored plan or letting the government assume these responsibilities through the public plan. Therefore, pay-or-play has the potential to be the more flexible of the two employment-based universal coverage requirements since it does not (if ap ropriately implemented) impose complex administrative burdens on employers that do not wish to assume them. Critics assert that both approaches could impose substantial economic burdens on employers (especially small employers) that may not be able to afford to finance health care coverage under such circumstances. Some critics also argue that relying on employment as the basis of coverage creates barriers to the portability of coverage when workers change jobs.

In contrast to the two employment-based approaches just discussed, ***ERIC*** also considered reliance on a coverage requirement imposed on individuals without requiring employers to provide coverage. An individual-based system of providing direct health care financing could take two main forms: a national health insurance program where everyone received coverage through a tax-financed public plan, or a mixed public-private approach where individuals had

a choice among a public plan, coverage voluntarily offered by an employer, or an individual insurance policy. The functional difference between the individual-based mixed approach and employment-based pay-or-play approach discussed above is that, under the individual-based mixed approach, individuals rather than employers would decide whether his or her coverage was obtained from an employer or from another nonemployment-related source.

While the individual-based mixed approach retains some of the current voluntary nature of employer-provided health care coverage, neither the individual-based mixed approach nor the individual-based national health program approach necessarily excludes employers from all obligations to finance health care. For example, proponents of both individual-based approaches have suggested that health care financing include increased corporate income taxes or another payroll tax in addition to personal income taxes, consumption taxes or sales taxes. Since roughly 85 percent of the population under age 65 now receives health care coverage through an employer, it is doubtful from a political perspective that any universal coverage requirement would be enacted that did not require employers to contribute a substantial share of the total cost of coverage.

Proponents assert that imposing a coverage requirement on workers rather than their employers has potential advantages of economies of scale, reduced administrative overhead, increased consumer awareness of cost and portability of benefits for mobile workers. Critics assert that both individual-based approaches have the potential disadvantage of requiring employers to finance health care without providing them a direct means to influence what health care is purchased or how it is delivered; that is, they have no control over purchases they are financing. In addition, public plans are subject to the vagaries of government bureaucracy, as well as the risk of budget-driven funding cuts that could undermine health care quality. The individual-based mixed approach has the further disadvantage of necessitating significant government regulation in order to control adverse selection by individuals and risk selection by insurers.

ERIC reached a preliminary consensus that none of the employment-based or individual-based approaches currently on the table are likely to achieve ***ERIC's*** direct financing goals without raising significant concerns for employers. There is a general preference among ***ERIC*** members for a mixed public-private health care system. There is some difference of opinion regarding relative preferences between employment-based and nonemployment-based approaches, however. Because there was no consensus on this point, the Interim Policy Statement outlines commonly agreed-upon actions that must be taken to reduce cost shifting and make health care financing more efficient.

4. Allocating health care resources more efficiently.

Overview: Commentators have identified several deficiencies in resource allocation within the health care system. These include, but are not limited to: poorly coordinated assessment, as well as inefficient dissemination and utilization, of new health care technologies; persistent costly excess capacity; and a clear insufficiency of resources in certain underserved communities.

Issue: whether resources can be allocated to address current inefficiencies without reliance on government intervention in the market place. ***ERIC*** acknowledges that there are flaws in the way resources have been allocated in the health care system as a whole. The difficulty of designing broad-based resource allocation strategies that do not invite unwarranted or counterproductive government interference with market forces proved to be a major obstacle to articulating a detailed implementation strategy. Rather than ignore the issue entirely, however, the Interim Policy Statement recognizes the need for coordinated resource allocation without offering a detailed strategy.

Several ***ERIC*** members questioned the ability of government to allocate resources more efficiently than the market place. ***ERIC*** does not believe that government should dictate or control resource allocation. Therefore, the Interim Policy Statement calls for increased cooperation among providers, patients and payers without identifying a government role in that process.

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VI. Conclusion.

This Interim Policy Statement reflects broad consensus on general principles of health care system reform within ***ERIC's*** membership, as well as a lack of consensus on certain strategies for implementing those principles. Thus, it mirrors the debate on health care system reform going on elsewhere.

For example, there is substantial agreement among ***ERIC*** members that the health care system requires reform, that such reform must be comprehensive rather than piecemeal, that such reform should define measurable quality standards and seek to eliminate cost shifting that results from uncompensated and undercompensated care, and that such reform must achieve effective cost containment before Americans can be guaranteed access to health care. Similar to the experience of others considering health care system reform, a diversity of views persists among ***ERIC*** members with respect to a number of key issues which require further consideration. These issues include the appropriate nature and degree of government intervention in the market place needed to ensure that health care costs are contained and that a means is provided for the direct financing of each individual's health care.

Achieving comprehensive health care system reform entails difficult trade-offs among competing interests and concerns. ***ERIC*** strongly encourages its own members, other employers, and all interested parties to develop their own positions. ***ERIC*** will revisit and refine its policy position as an increasing number of our members develop their own company positions and we learn more about the impact of health care system reform. By advancing the debate and refining our position, ***ERIC*** hopes to contribute substantially to the improvement of the nation's health care system and the quality of care for all Americans.

PREPARED STATEMENT OF JUDITH W. WAXMAN

Mr. Chairman and members of the Committee:

Thank you for inviting us to testify on this important bill. Families USA, is a nonprofit organization which advocates on behalf of families for comprehensive health care reform. Our work includes national advocacy as well as assisting state consumer groups on their specific state health care reform activities.

We want to take this opportunity to thank Senators Leahy, Pryor and Reigle for acknowledging our interest in the State Care Act of 1992, S.3180, in their statements when the bill was introduced. We are very supportive of the concept of providing federal support for state demonstrations of comprehensive health care reform, however, we do have some major concerns about certain sections of the bill. We gratefully appreciate your desire to continue to work with us to ensure the strongest possible bill.

We praise the sponsors of S.3180 for introducing a bill to help states enact comprehensive health care reform. The crisis in our health care system is widely acknowledged today by the general public, diverse interest groups, opinion leaders and policy makers. This recognition creates an historic opportunity to achieve meaningful and comprehensive reform of our nation's health care system. Although ultimate health care reform must be accomplished on a national level, some states, some of whom are represented here today by their Governors, are serious in their resolve to tackle this crisis. These states need encouragement and support to solve their dual problems of containing health care costs and providing universal access.

In the absence of federal leadership, states are becoming the policy making laboratories for change. Hawaii initiated the first employer mandate system. Massachusetts enacted a play or pay approach to universal access. Minnesota is establishing a statewide budget for health costs . Washington and Maine extended health care coverage for the uninsured who are ineligible for Medicaid. And you have heard from other states today about what they are doing. Significant initiatives in a variety of states hold great potential for assisting citizens of those states and informing the health reform debate at the national level.

We support the goal of the State Care Act of 1992 which establishes demonstration grants and a process for granting waivers from federal laws for states that initiate comprehensive health care reform. The stated goal for the states initiating reform is to ensure that every citizen has access to affordable health care coverage. Therefore, we believe it is consistent with that goal that federal assistance only go to states that intend to meet measurable goals of universal access and cost containment.

MEASURABLE STANDARDS

The cost containment goal of bringing down health care costs so that the increase in health costs equals the percentage increase in the gross domestic product by the end of five years is laudable in that it is specific and measurable. States that meet this goal will have satisfactorily contained their health costs.

The goal for coverage, contained in the bill, while specific and measurable, does not assure that every citizen will be able to obtain coverage. It falls far short of the goal of universal coverage. Setting a goal to cover 95% of the population is probably reasonable, since some segments of the population can be difficult to reach. Hawaii, however which is lauded for its coverage plan, has been able to cover 98% of its population.

The alternative coverage goal of an increase in 10% of the eligible state residents served is not acceptable. If one state, Hawaii, can achieve almost universal coverage, other states should be able to match this achievement. Additionally, cost containment can only be achieved with universal coverage. The cost containment goals contained in S.3180 will become increasingly difficult to reach the larger the percentage of uninsured people. In order to control costs, every person must be part of the system contributing premiums and uncompensated care for uninsured people must be eliminated.

WAIVERS

We recognize that states will need to obtain certain waivers from federal law in order to implement comprehensive reforms. The State Care bill correctly identifies provisions of ERISA, Medicare, and Medicaid as the appropriate statutes that will need to be reviewed to determine the necessary waivers.

We support the concept of allowing ERISA waivers for the narrow purposes stated in the Act. All employers must participate in any statewide health plan that is built upon employment related health care benefits. Because of the growing number of employers that rely on ERISA provisions to develop health benefit plans for their employees, ERISA waivers will be necessary for any comprehensive plan that involves employers.

We also support the waiver of Medicare reimbursement provisions which are also necessary and appropriate if states want to implement a statewide negotiated rate system.

However, we are concerned with the potentially broad latitude allowed for waivers in the Medicaid program. We know that negotiations are in progress to fulfill the sponsors original intention to protect the most vulnerable Medicaid beneficiaries. We are happy to work with you to assure that people who are mandatorily eligible for Medicaid under current law will continue to be eligible for all currently mandated services. We must point out, however, that about half of current Medicaid beneficiaries are covered at the states' option. These people are no less vulnerable than the mandatorily eligible population. S. 3018, as it is currently written could result in "optional" beneficiaries losing some or all of the benefits they now enjoy. The bill allows states to continue receiving the same amount of Medicaid funding even if they deny coverage to some people currently on Medicaid and decrease services to others. This would result in the creation of a block grant that allows states to shift funds from services for the very poor to give services to people who are somewhat better off. The decisions Congress has made about which people should receive priority for health care coverage could be wiped out. Protections for the "optional" beneficiaries must be included in the bill.

S.3018 allows states to request waivers from every state plan provision in Section 1902 of the Social Security Act. We question the need to allow waivers of every plan provision in Medicaid. Many of these provisions have been established though lengthy legislative negotiations over the past twenty-seven years, and many protect states as well as beneficiaries. These provisions include, for example, protections on confidentiality, requirements for nominal copayments, and requirements for provider licensing and certification. In another bill under consideration today, S. 3191, Medicaid rules on managed care plans will be changed to allow states greater flexibility in designing their delivery systems for Medicaid beneficiaries. The breath of the State Care Act language allows even these new changes to be totally disregarded.

Medicaid beneficiaries deserve the same protections given Medicare beneficiaries. The Medicare waivers in this bill are limited to reimbursement rules. We recognize that wider latitude will possibly be necessary in the Medicaid program, but allowing almost the entire program to be waived is overly broad. The obvious solution is to enumerate the specific provisions in Medicaid which could be waivable rather than, allowing the entire state plan, but for a few exceptions, to be waived. The breath of waivers under the State Care bill must be reviewed and narrowed.

BENEFIT PACKAGE

The language on minimum benefit packages is with some modifications, from S.1872, the Better Access to Affordable Health Care Act of 1991, the Senate bill on small group insurance market reform. We have previously testified that the standard benefit package in S.1872, which includes inpatient and outpatient hospital and physician services, diagnostic tests, mental health services, and preventive services, and coverage of prescription drugs, would constitute an adequate minimum benefit package. The standard package requires that no limit be set on the amount, duration and scope of benefits and requires specific limits on cost sharing.

We have also stated previously that the basic package, in S.1872, is "barebones" and totally inadequate. The basic package, only covers inpatient and outpatient physician and hospital services and diagnostic tests. Therefore, it specifically discriminates against people who have mental health problems. The basic plan has no amount, duration and scope requirements, which means that a plan that covers only one day in the hospital and one doctor visit would meet the requirements of this package. Also, there are no stated cost sharing limitations which means the plans can require any deductible or coinsurance amounts. Families covered by this plan may easily find themselves with such high cost sharing that they never see any reimbursement for health services.

Many people who might be covered by the basic benefit package may be worse off than if they had no coverage at all, because they will be paying a premium for insurance that will never help them. The basic benefit plan will not provide meaningful coverage for so many people that uncompensated care will continue to be a burden providers must bear. The basic benefit package must be eliminated as an option.

The ERISA section of this bill allows certain employee benefit plans to ignore these benefit package requirements if the employer makes a per-employee contribution toward health care costs equal to a certain stated amount. We are not opposed to the concept of allowing certain employers the leeway to design their own benefit packages. However, the extremely low contribution required by the bill, $1,250 a person and $2,500 for a family, is a reflection of the barebones package which we oppose. The average cost of health benefits per employee was $3,605 in 1991. The figures in S. 3180 are simply too low to represent meaningful coverage and should be increased.

COST SHARING PROTECTION FOR LOW INCOME PEOPLE

S.3018 does not specify any cost sharing protection for low income people. With no financial protection, low income people are in danger of receiving no coverage under this bill. Fewer than half of people whose income is under the federal poverty level are currently covered by Medicaid. S.3018, as it is currently written, contemplates that rules effecting some current Medicaid beneficiaries could be drastically rewritten. Millions of low income people who hope to get help under a new state plan, could find that the financial requirements imposed on them constitute a cruel joke. They would be required to pay amounts they do not have for benefits they would never receive, because they can never meet the deductible or coinsurance payments.

The minimum benefit packages required by this bill raise a very large question about what, if any, coverage low income persons will actually receive. Even under the "standard" package as set forth in this bill the potential out of pocket cost sharing is insurmountable for low income families. A 20% premium requirement plus a $700 deductible and 20% coinsurance for a family of three or four that makes $10,000, for example, puts health care out of reach. Even the $3000 out of pocket limit or, should the state choose, the optional alternative of 10% of wages, is impossible for poor families to pay. The "basic" benefit package presents an even worse scenario for low income people since it has no specified limits on costsharing. Financial protections for families whose income is up to at least 200% of poverty must be included as a requirement for approval of a state demonstration plan.

We want to continue to work with you and the states to achieve comprehensive health care reform. A carefully crafted federal bill can provide states with the incentives to solve their own health care crisis. Hopefully, the rest of us will learn important lessons for nationwide solutions. We look forward to continuing our work with you to make the State Care bill into legislation that will help millions of Americans.

You have also asked us to address The Medicaid Coordinated Care Improvement Act of 1992 (S.3191).

Families USA applauds Senator Moynihan's interest and commitment to find ways to increase access to high quality, affordable care for this nation's poorest citizens. Many states and policy makers are looking to manage care as a way to potentially save Medicaid costs, while at the same time increase access and efficient use of health care services. S. 3191 eliminates the current restrictions on Medicaid managed care plans and gives states considerable flexibility to require beneficiaries to obtain their health care through managed care plans.

We feel strongly that changes in federal requirements on managed care should move very cautiously. One of our primary concerns is that the financial incentives inherent in managed care can potentially lead to underservice rather than early and appropriate service of the health care needs of the enrolled population, especially because beneficiaries are not continuously enrolled in Medicaid.

The theory behind managed care is that an entity that receives capitated payments for patients will try to save money by keeping the subscribers healthy. The provision of preventive services and early diagnosis helps patients avoid costly services. The practices that work for the general population, however, may not work equally as well for Medicaid beneficiaries. First of all, Medicaid beneficiaries are frequently on and off the program. They do not necessarily stay on Medicaid for any continuous period of time. The incentive to save money for subscribers who will soon be receiving care elsewhere, may be to avoid giving them any services at all. There is no incentive to keep someone healthy if you will not be responsible for their care in a short period of time. S. 3191 would be improved significantly if it included a provision to assure that all beneficiaries enrolled in a managed care plan would maintain their eligibility for a set period of time, such as six months or a year.

The states' desire to significantly save costs through managed care also makes us dubious about the quality and quantity of services that will be provided. Medicaid is already the lowest payer, often reimbursing providers far below what even Medicare pays. Given the current underservice and fragmented care beneficiaries receive, even maintaining current federal payments could mean lower quality care or a dangerous curtailment in services. Also, most managed care plans reduce costs by reducing hospital days. Since the largest percentage of beneficiaries is women and children who are not the biggest users of hospital care, and therefore the potential savings may be overestimated. Finally, new managed care systems require considerable administrative costs associated with start up and creating oversight and quality assurance mechanisms. States that want to establish effective, high quality systems may find that spending less than they currently spend on Medicaid may be very difficult.

Despite some success stories in specific localities, Medicaid managed care has a checkered past, at best. Quality of care has not proven to be consistently higher than in non-managed care settings. Marketing tactics have included discrimination against people with potentially high health care needs and misinformation about the programs' benefits and restrictions.

Some consumer protections such as the requirement that beneficiaries can chose between plans and that grievance procedures be included are addressed in the bill. Yet, there are still many unanswered questions about how critical consumer protections should be designed. Specifically, it is necessary to assure that managed care plans will remain solvent; that the financial risk placed on providers leads them to reduce unnecessary care, but does not provide incentives to skimp on care, to save costs and increase profits; and that capitation rates are sufficient to assure that the plan has the resources to provide all medically necessary services.

A 1986 Rand Corporation study showed that low income people had worse health outcomes than others enrolled in HMOs due to barriers to care, including understanding and following plan procedures for obtaining care. More attention needs to be paid to the provision of continuous education, the presence of a patient advocate to assist enrolles in how to use the plan, how to appeal decisions or how to switch plans, if necessary; and restrictions on marketing practices.

People with disabilities and other chronic health conditions have their own specific concerns about managed care. They are afraid that they are more vulnerable to being denied the specialized services they may need. They must have assurances that, for example, extensive hospitalization or rehabilitation is allowable and that there is continuous availability of and access to specialty providers.

The lack of specificity in the bill on these crucial aspects of consumer protection leads us to conclude that Medicaid beneficiaries should not be subjected to mandatory wholesale shifts into capitated delivery systems at this time. If the Medicaid managed care "success stories" can provide the answers to the questions raised on consumer protections, then those details should be reflected in the bill. The inclusion of specific criteria taken from plans that have worked would be a significant addition to the bill.

We believe that S. 3191, in its current form, creates more problems for beneficiaries than it solves. There are simply too many gaping holes in S. 3191's ability to assure against the potential harm of mandatory enrollment in a plan established to provide comprehensive health care and save money.

February 3, 1993

The Honorable Patrick Moynihan
% Finance Committee
United States Senate
Washington, DC 20510

Dear Senator Moynihan,

This letter is a follow-up to our conversation at the September 9, 1992 hearing on Managed Care in Medicaid.

This letter reviews some of the major problems over the last ten years experienced by Medicaid and Medicare beneficiaries in managed care plans. The purpose of reviewing this history is to identify key consumer protections, especially for vulnerable populations, that should be incorporated into any proposal that promotes managed care. Such protections have

already been incorporated into many managed care programs. These protections ensure that managed care plans deliver high-quality, cost-effective care to all types of consumers.

MEDICAID

Over the last ten years Medicaid beneficiaries have experienced serious problems in managed care programs in a significant number of places, including Arizona, Philadelphia, Chicago, and Dayton. These have been documented by the GAO, by the HHS Inspector General, by legal services advocates, by journalists and others. Some of the problems have been closely related to the nature of the current Medicaid program, particularly low reimbursement rates and turnover of eligible persons. These problems ultimately must be addressed by a reformed health care system that guarantees universal access and *fully integrates* care to low income persons with care to others. In the meantime, higher reimbursement rates and a longer period of guaranteed eligibility would go a long way to protect Medicaid beneficiaries in managed care plans.

Listed below are specific highlighted problems and suggestions for solutions.

Problem—Inadequate risk-sharing, incentives to underserve

The GAO criticized Chicago health maintenance organizations for passing down to individual physicians, through a capitated payment system, the financial risk of providing care to Medicaid beneficiaries. This resulted in a large amount of risk being placed on an individual physician or small group of physicians, and increased the likelihood of underservice.[1]

Protection—Limits on physician incentives, provisions for stop-loss

Standards for managed care organizations should allow risk-sharing only at the organizational level where the enrollment is sufficient to support it, and not at the level of individual physicians. Incentive arrangements between the organizations and individual physicians should be based on treatment decisions made by all physicians about all patients.

The GAO cited Oregon's optional state-sponsored stop loss insurance to limit the financial risk physician care organizations face as another means of guarding against inappropriate service reductions.

Problem—Lack of quality assurance

In Chicago, over 58,000 Medicaid beneficiaries voluntarily left their HMOs during fiscal years 1986 through 1988 to return to fee-for-service. Even when confronted with this turnover rate, the State did not move quickly to investigate the problem.[2] The State did not have any independent information, such as patient satisfaction surveys, with which to evaluate the problems.

A March 1992 report by the Legal Aid Society of Dayton Inc. documented that a declining number of children were getting legally required medical exams and a suspiciously low number of them were being referred for follow-up care; that primary care visits by plan participants had declined substantially more than had emergency room visits (clients were using the emergency room because of difficulty getting appointments); and that the plan's ratio of primary care physicians to patients had dropped. Only 29% of enrolled pregnant women in 1989 received prenatal care in their first trimester, while the percentage for Medicaid recipients in other parts of the state with fee-for-service care was 35%. An independent, out-of-state evaluator faulted Ohio officials for failing to review the care received by the plan's Medicaid enrolles.[3]

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[1]GAO, *Medicaid: Factors to Consider in Expanding Manage Care Programs,* Testimony before the subcommittee on Health for Families and the Uninsured of the U.S. Senate Committee on Finance, April 10, 1992, GAO Report, HRD92-26.

[2]*Ibid.*

[3]Julie Kosterlitz, "Managing Medicaid," *National Journal,* May 9, 1992, pp. 1111-1115.

Protection—Independent reviews, specific standards

The GAO has cited Oregon's quality assurance program as a model of the kinds of safeguards states must implement to ensure that recipients receive adequate levels of health care. The State annually contracts for an independent review of medical records. The state further assesses quality through client satisfaction and disenrollment surveys, and a grievance procedure.

The Arizona AHCCCS program annually reviews patient records for certain ailments to compare outcomes and procedures across time and between plans.

The following kinds of specific standards would protect against the deficiencies described in Dayton: physician to patient ratios (for both primary care and specialty providers; standards for waiting times for both routine and urgent care; requirements for geographic accessibility and accessibility by public transportation; requirements for language translation services; and standards for preventive care and timeliness of prenatal care.

All plans should have well-defined grievance procedures. When a patient is denied services, the plan should provide the patient with a written notice giving the reason for denial and the process for appealing. The patient should be able to get timely appeals decisions from an authority not involved in the original decision.

Problem—Inexperience, poor management

Both Arizona and Philadelphia established managed care programs that they claimed would revolutionize the delivery of health care to Medicaid beneficiaries. In both places, however, new managed care entities proved incapable financially and administratively of handling the demands of the enrolled populations. In the early days of the AHCCCS program in Arizona, the State had to take managerial control of the program from the original contractor who proved incapable of administering the system. Philadelphia's HealthPASS program has experienced similar start-up problems. In 1987, the GAO questioned the quality of care provided by Philadelphia's HealthPASS program. In 1989 the private contractor that was running the plan went bankrupt, leaving area hospitals with an estimated $30 million in unpaid bills. In 1990, the HHS inspector general questioned the bidding process the state used for finding a new contractor. A year later, the inspector general questioned the contractor's profits.[4]

These kinds of administrative problems interfered seriously with poor beneficiaries' ability to obtain needed health care services.

Protection—Strong standards, solvency standards

The kinds of quality standards described above, combined with specific solvency standards, can help prevent managed care entities with inadequate financial resources and experience from taking on too much risk and responsibility.

Problem—Poor access

A Rand Corporation study found that low income persons with health problems

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[4] *Ibid.*

appeared worse off at Group Health Cooperative, an HMO, than with both free and pay fee-for service. This population group had more bed-days per year due to poor health and more serious symptoms than those assigned fee-for-service care, and had a greater risk of dying. This contrasted with the results for a high income group with health problems. The researchers suggest that poor people may be less successful in obtaining the care they need because of barriers to access such as telephone-based appointment queuing systems, restrictions on use of emergency departments, and greater difficulty in arranging transportation to central locations. The authors note that HMOs place greater responsibility on individuals for follow-up and compliance with medical regiments and do not have an immediate financial incentive to ensure that needed follow-up care is obtained.[5]

The Group Health Association of America has also reported that Medicaid members often have problems understanding and accepting managed care requirements and limitations.[6]

Protection—Patient advocacy systems

Some HMOs have provided special outreach programs for poor patients. The Rand researchers concluded, "Special provisions may be required, especially for the poor with health problems, to minimize the possibility that HMOs achieve cost-savings at the expense of health." These might include patient education briefings, translation services, special efforts to assure transportation, special efforts to ensure follow-up treatment, and the creation of a patient advocate position.

MEDICARE

Medicare beneficiaries have experienced many of the same problems as Medicaid beneficiaries in some managed care programs, particularly HMOs with rapidly growing enrollments in Florida. The Humana plan in Florida enrolled approximately one out of seven of the Medicare beneficiaries in HMOs nationwide. The problems highlighted below are those that relate most specifically to rapidly increasing the number of vulnerable persons, in this case the elderly, in new managed care entities.

Problem—Inexperience, poor management

International Medical Centers (IMC) was one of the Reagan administration's model Medicare HMOs, beginning in August 1982. As early as 1980, there was evidence of shaky finances partly caused by the IMC president's tendency to borrow huge sums from the HMO with little collateral and to employ family members and associates at high salaries. In 1987,

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[5]John W. Ware, Jr., Robert H. Brook, *et. al.*, "Comparison of Health Outcomes at a Health Maintenance Organisation with Those of Fee-for-service Care," *The Lancet,* May 3, 1986, pp. 1017-1022.

[6]M.R. Traska, "Medicaid HMOs: Endangered Species," **Perspective**, *Medicine and Health*, May 8, 1989.

three IMC officials were indicted on bribery and wiretapping charges; the state of Florida took control of IMC and sold it to Humana; and the U.S. claimed IMC owed $12 million for Medicare overpayments.[7]

Humana's rapid growth as a Medicare HMO has led to shaky finances (ordered by the State to take corrective action in 1989 because profits were below 2 percent of revenues); numerous consumer complaints; and the closing of 60 health care centers in Florida. More than 5,400 complaints about the Humana plan in Florida have been filed with the U.S. government since June 1987, from failure to pay bills to government enrollment errors.[8]

Protection—Strong standards, timely enforcement

In the case of both IMC and Humana, federal and state regulators have been aware of problems. The federal government failed to enforce vigorously its requirements for Medicare contractors. State and federal regulators take months to resolve individual complaints.

Problem—Marketing

Hundreds of Humana members have complained that they were signed up for the HMO without understanding how it worked. Sales agents who use illegal enrollment practices almost never get prosecuted. Humana members experience great difficulty disenrolling from the plan.

Medicare beneficiaries in Los Angeles have also been subjected to high-pressure marketing tactics that result in individuals enrolling in HMOs without understanding the consequences. In Los Angeles, this has been particularly common among the elderly who do not speak English.[9]

Medicaid beneficiaries have also been enrolled in HMOs without adequate education about the consequences.

Protection—Strong marketing standards and enforcement

Information for individuals on available managed care plans should be in a standardized format that it is easy to understand and that allows consumers to easily compare plans.

Federal officials received at least 186 cases alleging improper Humana enrollment,

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[7]Nancy M. McVicar, Fred Schulte, and Jenni Bergal, "The Misery of IMC," *Sun-Sentinel*, October 21, 1990.

[8]*Ibid.*

[9]Information provided by the Medicare Advocacy Project, Los Angeles.

but no action had been taken by HHS investigators.[10] There is no national policy on the use of commissions by HMOs to pay agents, even though officials agree that commission structures provide incentives for unscrupulous marketing practices. One HCFA regional official proposed in 1987 that Medicare beneficiaries sign up for HMOs at Social Security offices, which currently have the authority to disenroll Medicare beneficiaries from an HMO.

Problem—Underservice, failure to pay bills

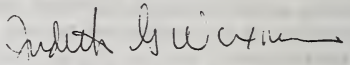
At least 430 complaints from doctors, many of them specialists, were filed with state and federal officials seeking help with getting Humana to pay bills. "Humana has compromised patient care by not paying for services provided to their members," wrote one head of a medical group to Florida insurance officials.[11]

Protection—Quality reviews, better enforcement

Federal regulations require Medicare HMOs to pay bills promptly and Humana has been cited by federal officials for failure to do so. There were apparently no further consequences.

I hope the above information is useful in your deliberations about Medicaid managed care plans. Please let me know if any additional information on these issues would be helpful.

Sincerely,



Judith G. Waxman
Director
Government Affairs

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[10]"Commission fever can lead agents to abuse system, Enforcement lax on sales tactics," *Sun-Sentinel*, October 22, 1990.

[11]"Patients feel betrayed by HMO, Gold Plus Plan members cite headaches trying to get bills paid," *Sun-Sentinel*, October 23, 1990.

PREPARED STATEMENT OF SENATOR PAUL WELLSTONE

Mr. Chair, I'd like to thank you and the Committee for the chance to speak to you very briefly today about the reaction in Minnesota to S. 3180, the State Care Act of 1992.

As you know, I am an original co-sponsor of this bill. Like my colleague on this Committee, Senator Durenberger, I am very proud of the kind of health care reform legislation the state of Minnesota has been able to hammer out on a bipartisan basis.

I am certainly also a strong supporter of comprehensive, single payer national health care reform, as proposed in my own bill, S. 2320. At the same time, I think we have a responsibility at the federal level to support genuine attempts by the states to ease their health care burdens.

The parties who developed HealthRight in Minnesota, the legislature, the Governor's office, and the state Department of Health, have collaborated on a series of proposals they believe would strengthen S. 3180. They have commented that the bill would be of great help to their efforts. Their proposals focus primarily on the difficulty Minnesota will have in meeting the bill's criteria to qualify as a demonstration project. I support the need in general for criteria regarding expanded access and cost control. These are necessary for the protection of the people who are meant to benefit from health care reform, and as clear objectives for the programs. It is also clear that states such as Minnesota that have already made a sincere effort at reform may need greater latitude if they are to meet federal criteria that were developed after the state plan was enacted.

I am confident, Mr. Chair, that Senators Leahy and Pryor will be open to reviewing these comments as we continue to work together on this bill, and that the state is also open to compromise. I am hereby offering the remarks from Minnesota into the record of today's hearing, and thank you again for the chance to speak before you.

Attachment.

LEAHY-PRYOR STATE CARE ACT OF 1992 (S. 3180)

COMMENTS AND PROPOSED REVISIONS

I. Summary

The State of Minnesota strongly supports the purpose of Leahy-Pryor, to promote state health care reform efforts by providing federal resources and by using waivers to lower the federal law barriers to state reform. Such a bill would make the federal government a help rather than a hindrance to states seeking workable solutions to the health care crisis.

However, the current language of the Leahy-Pryor bill would unintentionally exclude -those states most worthy of federal support: states such as Minnesota that have already begun moving forward by enacting health care reform legislation. We urge that the language of the bill be modified to include such states. Such states should also be given the opportunity to seek the waivers provided under the bill without having to first await the results of a grant application. Finally, those waivers should be broadened slightly to better accommodate attempts by states to implement meaningful, system-wide reform.

II. Suggested Changes

Section 2103(a)—replace the sentence that begins . . . "The preceding sentence . . ." with the following:

The preceding sentence shall not apply to any state which has enacted a health care reform act. A health care reform act is any state legislation enacted after January 1, 1992 that seeks, in the determination of the Commission, to bring access to health care to a substantial number of uninsured eligible state residents and to substantially limit the growth of health care spending, while preserving the quality of health care provided. In making its determination of whether legislation is a health care reform act, the Commission may consider the elements listed in section 2105(b), but shall not require that each such element be satisfied. The Commission shall determine no more than five states to have enacted health care reform acts.

Section 2104(c)(2): Add the following:

The Commission may waive any of the requirements of Section 1902 or 1903 upon a request from any State that has enacted a health care reform act, as determined by the Commission under Section 2103(a). Such a waiver may be granted only if the State satisfies the requirements of sections 2105(b)(17) and 2105(b)(18).

Section 2105(b)(2)—Add subsection (C), as follows:

(C) adults not entitled to benefits under Title XVIII or Title XIX, an upper limit may be placed on inpatient coverage.

Section 2105(b)(2)(B)—After " . . . under such title," add:

However, such benefits and services may be delivered differently then they had been previously, pursuant to waivers applied for under Section 2104(c)(2) or to approved amendments to the state plan under Title XIX.

Section 2105(b)(4): Rewrite as follows:

(4) provide for the development and implementation of appropriate cost control mechanisms, such that the annual increase in per capita statewide health care costs *for 1994 and each subsequent year of the demonstration project is reduced by ten percent from the rate of increase for the preceding, year.*

Section 2105(b) (10) (A)—Change " . . . Policy and Research, and . . . " to:

. . . Policy and Research, *or other practice guidelines approved by the State government,* and . . .

Section 2108: Reword beginning of section, as follows:

With respect to any state care demonstration project approved by the Commission *or any state legislation determined by the Commission to be a health care reform act,* . . . .

Section 2108(2)(B)(ii): add:

and a database on health care costs and expenditures, including costs and expenditures made prior to the enactment of this Title.

III. Discussion

Section 2103(a) of the current version of Leahy-Pryor requires a state that desires either a grant or a waiver to first create a state agency called a State Health Care Authority, which would then produce a "state plan" along the lines detailed in the bill. The only exception is for states which have already enacted such "state plans" within 12 months of enactment of Leahy-Pryor. That exception is intended to allow states that have already passed reform legislation to participate in the reform activity promoted by Leahy-Pryor, without having to start over by creating a State Health Care Authority. However, requiring that state legislation passed months ago strictly conform to a detailed laundry list of items subsequently mandated by Congress is the wrong way to achieve that goal.

Reform legislation already enacted by Minnesota and other states will not meet the proposed definition of "state plan." As detailed in Section 2105(b), a "state plan" must satisfy 19 different requirements. Some of these requirements are impractical:

- Section 2105(b)(2) requires all participating states to use the same "standard benefit packages" detailed in subsection 2105(c)(1) or 2105(c)(2)—this limits the extent to which states can experiment with health care reform, thereby undercutting the purpose of the bill. More specifically, the bill's benefit packages differ from the benefit package carefully worked out by Minnesota in its 1992 legislation, and would therefore require Minnesota to redesign its reform effort. The existing Minnesota benefit package emphasizes primary care and prevention, and provides comprehensive care for children. However, inpatient benefits for adults are capped at $10,000, because the state's statistician and the independent actuaries retained to study the benefit package determined that such a limitation was necessary to prevent private employers from dropping health insurance coverage in order to dump their employees into the state program. Mandating full inpatient coverage, as the current version of Leahy-Pryor would, would undo a policy decision painstakingly reached by Minnesota, and require us instead to adopt a federally mandated approach that our experts have projected would be far less likely to succeed.
- Section 2105(b)(10)(A) requires that practice guidelines developed by the federal government be used—Minnesota's legislation emphasizes the development and use of practice guidelines but calls for the state, drawing on the expertise of its Practice Parameters Advisory Committee, to determine whether to use federal practice guidelines, modify those guidelines, or choose guidelines developed by the state government or by the private sector.

In addition to such impractical requirements, at least one Leahy-Pryor state plan requirement is literally *impossible* to apply to existing state legislation: Section 2105(b)(15) requires that the state plan "provide for a database infrastructure under guidelines developed by the Commission under Section 2102(c)(1)(C);" however, the

"Commission" is a creation of Leahy-Pryor, and therefore neither it nor its guidelines yet exist.

While Minnesota's 1992 health care reform legislation is a sincere and ambitious attempt to bring real reform to the system in order to contain costs and increase access without sacrificing quality, it does not include every one of the 19 items in the state plan checklist. We suspect that the same is true of the handful of other states that have already acted, such as Florida and Vermont:

In order to promote reform efforts by those states, the language of Section 2103(a) must be made more general and less exclusive. States that have already passed legislation should not be judged retrospectively on the basis of a long' checklist, but rather should 'be allowed to participate if their programs are genuine attempts, as determined by the Commission, to bring access to the uninsured while holding down the growth rate of health care spending Once the Commission gives such approval to existing state legislation, those few states should be permitted to seek waivers immediately (under the current version of Leahy-Pryor, a state can seek waivers only after applying for and receiving a grant).

Other, changes that we have suggested are essentially technical. We have suggested several modifications to the state plan section that we believe are more realistic or more in keeping with the bill's intent. We have also suggested several minor clarifications to the ERISA preemption section.

COMMUNICATIONS

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association (AHA), representing 5,400 hospitals, appreciates the opportunity to share its views in regard to state autonomy for health care revision, particularly, S. 3180, the State Care Act of 1992. This bill would provide a streamlined waiver approval process and development and implementation grants for up to 10 states that develop health care reform plans meeting requirements specified in the bill. Under this bill, waivers of certain Medicare provisions, Medicaid provisions, and provisions of the Employee Retirement Income Security Act (ERISA) would be allowed. In the absence of national health care reform, this bill is designed to make it easier for states to Pursue needed changes in their health care systems. The AHA has been working to develop a vision for national health care reform that guarantees universal access for all to a basic set of health care benefits and controls costs by fostering economic discipline on the part of hospitals, physicians, insurers, and patients. In previous testimony before this committee, we have described how universal access would be achieved: through a pluralistic system of financing that emphasizes expanded employment-based coverage of health care and through a new public program that consolidates and expands Medicare and Medicaid and includes individuals unable to obtain health benefit coverage through their place of employment. Under the AHA plan, economic discipline would be achieved by restructuring the health care system into community care networks and realigning financial incentives. We envision community care networks as consortia of varying combinations of groups such as hospitals, physicians, other practitioners and providers, insurers, and community agencies organized at the local level to provide a continuum of care to an enrolled population. The networks would be paid a fixed annual payment per individual. In return, networks would be expected to provide patients with a broad, coordinated continuum of care, with the overriding goals of maintaining and improving the health status of their communities and achieving greater value for the resources consumed. Community care networks hold the best promise for reducing needless competition in our system, eliminating unnecessary duplication of services and capacity, and improving the health status of our communities through preventive and other measures.

The AHA supports state experimentation and flexibility in improving the health care delivery system, but S. 3180 is so directive in its state health care plan requirements that it severely limit states' options and their ability to pursue the development of integrated community care networks. A more flexible approach is necessary.

Of particular concern are the state-wide cost control mechanisms required by the bill. The streamlined waiver process and implementation grants would be available only to states that enact budget caps tying growth in health care costs to the rate of growth in the Gross Domestic Product. The AHA opposes such federally imposed expenditure caps. The bill proposes that funding be arbitrarily set rather than rationally linked to the reasonable cost of a defined set of benefits for various population groups.

The bill also extends the micro-management of health care prices and service use rather than restructuring the delivery system and the incentives that drive it. Community care networks offer needed delivery system change. Networks would receive a set fee per year for each patient enrolled, which would establish their budgets for delivering care. Knowing that payments coming into the network are fixed, providers as partners would have a financial incentive to coordinate services and reduce unnecessary care and duplicate services.

In addition, the bill specifies that spending for Medicare and Medicaid under the state plan must be budget-neutral—no higher than what spending otherwise would have been. In the case of Medicaid, this raises a fundamental question of whether states would continue to be obligated under the Boren amendment to ensure that

state Medicaid payments are reasonable and adequate. This important protection for access to and quality of care must be maintained.

The minimum standard and basic benefit packages described in the bill are limited in their requirement to cover certain services, and the decisions to include or exclude services do not appear to be based on any measure of medical effectiveness or cost effectiveness. This benefit package will become the core of health care coverage in selected states. It is important that the minimum benefit package be as broad as possible and that no type of service be excluded arbitrarily from coverage.

The bill allows states to charge premiums, co-payments, and deductibles within certain limitations, but provides no protection for low-income residents. It is important that consumer cost-sharing not stand as a barrier to anyone, particularly low-income individuals, seeking needed care.

Another concern stems from the fact that the quality assurance sections of S. 3180 are weak. While states are required to provide satisfactory assurances that necessary safeguards are taken to protect the health of residents, no guidelines are specified for judging this. Aggregate measures of care outcomes and health status improvement, the conduct of self-evaluations, and the provision of performance feedback to providers would be important additions.

There is little gain for the Medicaid patient—or for any patient—in terms of improved access to quality care if reforms are used solely as a means of controlling expenditures, rather than managing patient care more effectively.

To truly ease the way for state experimentation and reform of the health care system, changes to ERISA need to be implemented now for all states rather than on a demonstration basis. Specifically, self-insured employers should be subject to the same state rules as other employers who purchase private coverage so that incentives for promoting community care networks or any state assessments designed to finance and expand access to health care would apply equally to all employers.

This bill, as well as others currently under consideration, such as S. 3191, the Medicaid Coordinated Care Improvement Act of 1992, attempt to provide needed relief to states from the complex federal waiver process. The AHA, jointly with the Association of American Medical Colleges, the National Association of Children's Hospitals and Related Institutions, and the National Association of Public Hospitals have proposed improvements to S. 3191. Attached to this statement is an August 31, 1992 letter to Senator Daniel Moynihan, one of the principal sponsors of the bill, from the four associations that outlines concerns and recommends changes. But while the goal of providing states relief from the cumbersome federal waiver process is laudable, it should never be at the expense of jeopardizing access to high quality care.

The challenge of health care reform is to find an acceptable balance between expanded access and cost containment while at the same time promoting continued improvement in the quality of health care we provide. We will continue to work with our member hospitals, with others inside and outside the health care field, and with members of Congress to develop a workable vision and set of strategies for the future.

Hon. DANIEL PATRICK MOYNIHAN,
U.S. Senate,
Washington, DC.

RE: S. 3191, the "Medicaid Coordinated Care Improvement Act"

Dear Senator Moynihan: Our four associations represent hospitals throughout the country, which are major providers of care to indigent patients, including individuals eligible for Medicaid assistance. They also include hospitals with extensive experience with managed care—both commercial and Medicaid financed—as providers serving plan enrollees and as managers of plans. Because of this experience, our member hospitals recognize the potential role managed care can play in improving Medicaid recipients' access to timely and appropriate health care services.

We believe that legislative proposals to stimulate managed care enrollment among Medicaid recipients can represent responsible federal policy initiatives, *provided* they are accompanied by protections for Medicaid recipients and their health care providers to ensure that the goal of improved access to appropriate care is not undermined by state budgetary pressures for cost containment and risk transfer.

We have appreciated the opportunity your staff has given us to identify ways to incorporate such protections in S. 2077, the "Medicaid Managed Care Improvement Act. " We believe that several revisions you have included in S. 3191, the "Medicaid Coordinated Care Improvement Act," are important first steps in addressing the issues we have raised. We urge your support for additional revisions when the Finance Committee acts on this bill.

Fundamental to the concerns of our member hospitals has been the widely recognized inadequacy of Medicaid reimbursement for hospital care and the potential for states, in response to serious budgetary pressures, to use managed care to ratchet down further Medicaid reimbursement. This concern has been heightened by the requirement in both S. 2077 and S. 3191 that funds devoted to Medicaid managed care, including its administrative costs, cannot exceed in aggregate the already inadequate funding that in many cases exists under Medicaid fee-for-service.

This requirement amounts to an explicit ceiling on the already limited amount of Medicaid funds that may be devoted to managed care. In response, we have not sought either to oppose this cap—although it gives our members great concen—or to recommend a floor under Medicaid managed care reimbursement to hospitals, as you suggested in describing our recommendations in your August 12 statement in the *Congressional Record.* However, we have strongly recommended the explicit application of essential payment assurances now in federal Medicaid law to Medicaid managed care. The most important of these assurances are the Section 1902 "Boren amendment's" guarantee of reasonable and adequate payment for "efficiently and economically" operated facilities and the Section 1902 and 1923 requirements for payment adjustments to reflect the circumstances of hospitals serving a disproportionate share of low income patients. Neither of these requirements, which have been a part of federal law for more than a decade, even remotely resemble a Federal floor.

THE BOREN AMENDMENT

The Boren amendment does not contain a specific standard for reimbursement; nor do federal regulations implementing the Boren amendment; nor do numerous judicial opinions on the law. Instead, the Boren amendment simply requires that states demonstrate that they have determined the rates of Medicaid reimbursement received by hospitals are adequate to meet the costs of "efficiently and economically" operated facilities, with the states given the flexibility to define their own standards for efficient and economical hospital operation. If any state opposes the extension of such a standard to Medicaid managed care, does it mean that it is willing to tolerate payment rates that would be insufficient to sustain efficiently and economically operated hospitals?

Unlike S. 2077, S. 3191 recognizes the potential for managed care in some instances to be used by states to ratchet down Medicaid payments. The new bill authorizes an annual study of Medicaid managed care payment rates relative to Medicaid fee-for-service rates. We believe this is an important addition to the legislation, and we recommend that it be further amended to require a comparison of Medicaid managed care payment rates to both commercial managed care and private fee-for-service rates. However, as useful as such a study will prove to be, it is no substitute for preservation of a legal obligation on the part of each state to as sure adequacy of payment under Medicaid managed care. Our associations remain committed to working with you and members of the Finance Committee to address this need in final legislation.

DISPROPORTIONATE SHARE PROTECTIONS

Our recommendations for explicit application of federal disproportionate share payment requirements to Medicaid managed care also do not represent in any way a floor under reimbursement. Since it established the disproportionate share requirement in 1981, Congress has amended the law several times to strengthen the requirement. But not once has Congress required states to provide a specific amount of disproportionate share adjustment or to extend such adjustment to a specific number of hospitals. The amount and scope of the adjustment are left to the determination of the states, within broad parameters.

We are encouraged that unlike the original bill, S. 3191 recognizes the importance of disproportionate share requirements by stating, "Nothing in this section shall affect any requirement on a State to comply with section 1923." However, this provision does not go far enough, because a number of states, apparently with the acceptance of the Health Care Financing Administration, are now using Medicaid managed care to escape payment of disproportionate share payment adjustments. Some states use a Medicaid utilization rate formula to determine qualification as a disproportionate share provider, but they do not count Medicaid managed care days in the calculation. Other states use a Medicaid utilization formula to determine the amount of the payment adjustment, but they do not count Medicaid managed care days in the calculation. Finally, some states simply do not make any disproportionate share adjustment for Medicaid managed care days. We are committed to working with you and the committee to make explicit in the legislation that such cir-

cumvention of disproportionate share law is not permissible under Medicaid managed care.

ADDITIONAL PROTECTIONS

There are a number of additional issues which we are pleased to see S. 3191 begins to address, but which we believe deserve further attention.

- *Arbitrary Limits on Medically Necessary Care for Young Children.*—S. 3191 references current law's prohibition on durational limits and dollar caps on medically necessary inpatient care for exceptionally ill children in disproportionate share hospitals. The bill should be amended to reference the additional protection in current law—the requirement that states with prospective payment should provide outlier adjustments for cases of medically necessary inpatient care for young children in disproportionate share hospitals.
- *Insolvency Standards.*—S. 3191 recognizes the need for minimum standards to protect against plan insolvency by requiring the Secretary of the Department of Health and Human Services to issue standards for plan solvency. The bill should be amended to require the Secretary, as part of this effort, to address specifically the state's responsibility for legitimate unpaid provider claims in the instance of a Medicaid managed care plan filing for protection against insolvency in the bankruptcy courts.
- *Special Health Care Needs.*—S. 3191 recognizes the circumstances of children with special health care needs by giving their families the option not to enroll them or to disenroll them from Medicaid managed care plans. The bill also authorizes a federal study of how Medicaid managed care can best address both the care coordination and financing of care required by these children. S. 3191 should be further amended to address the comparable circumstances of adults with special health care needs. The bill also provides that until such time as the federal study is issued and acted upon by Congress, care provided to people with special health care needs, regardless of whether they are enrolled in managed care, should be reimbursed on a fee-for-service basis.
- *Medical Screening Fee.*—S. 3191 addresses the need for reimbursement when a Medicaid plan enrollee seeks out-of-plan care that is "immediately required." S. 3191 should be further amended to require that Medicaid managed care plans should pay a "screening fee" to compensate hospital emergency rooms for performing legally mandated medical screens on all patients, regardless of whether the managed care enrollee is determined as a result of the screen to require immediate care.

Thank you for your continued consideration of the concerns of our member hospitals as they seek to sustain and improve service to millions of indigent and low income patients during times of increasing fiscal constraints in both the public and private sectors.

Sincerely,

American Hospital Association; Association of American Medical Colleges; National Association of Public Hospitals; National Association of Children's Hospitals and Related Institutions.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

The AMA is pleased to have this opportunity to submit this testimony to the Committee regarding the need for immediate and intensive legislative reform of the Employee Retirement Income Security Act of 1974 (ERISA) and its application to health benefit plans. As long-term advocates of a federal health care policy that would include ERISA modification, we continue to underscore the importance of amending ERISA to enable the goals of health system reform to go forward successfully.

The nation's growing gaps in health care coverage -- nearly 37 million people uninsured, 20 million under-insured, and another 63.6 million temporarily uninsured -- must be addressed. Unfortunately, states working to solve this exigency through the development of funding pools and other ways to cover the uninsured consistently have been blocked by ERISA and its pre-emption of a funding scheme that impinges on self-insured plans.

Even long-developed state plans, such as the hospital surcharge plan to cover charity care in New Jersey, have been eviscerated by court holdings that ERISA precludes state regulation of self-insured health benefit plans. Courts consistently have upheld ERISA pre-emption as a rationale to block the involvement of self-insured plans, no matter how necessary such measures are to effect health reform, and regardless of how many people in the state are suffering because of lack of access to care or inability to obtain health insurance.

As physicians and patient advocates, we deal on a daily basis with self-insured benefits plans and we see the painful microeconomic effects, or human consequences, of ERISA pre-emption. A self-insured plan, because of ERISA, can arbitrarily deny benefits to a patient, no matter what kind of illness or need is involved, with virtual impunity. The U.S. Supreme Court held in Pilot Life Insurance v. Dedeaux that even bad faith insurance practices by a self-insured plan are immune from state action under ERISA. Unfortunately, the ERISA statute lacks any substantial federal penalties to deter such actions.

Consequently, self-insured plans increasingly have resorted to practices that avoid paying for costly health care benefits in the name of cost containment. ERISA plans also have begun to discriminate against employees with catastrophic illnesses by slashing their benefits to cut costs. This unconscionable policy was highlighted by the recent Greenberg v. H & H Music Co. case. In Greenberg, the courts upheld the company's action to cut the benefits of a dying employee, during his course of treatment, from a $1 million lifetime cap to only $5,000 for any AIDS-related treatment. While such action clearly would have been prohibited by state anti-discrimination laws, the federal courts held that the plaintiff had no remedy under ERISA because the cut would result in plan cost savings.

The company's decision in Greenberg, and the allowance of such an obviously unjust social policy, cannot help but shock us. Under traditional contract law, an insurance plan cannot arbitrarily decide not to carry out its obligation to provide benefits because the patient becomes sick, nor can it unilaterally change contract terms to avoid the original terms. Under current ERISA law and ERISA plans, however, these cases are increasing. And as long as ERISA is a legal reality, cases like Greenberg will continue, forcing more patients who thought they were protected by their health benefits into an increasingly fragile safety net of Medicaid or charity care. The AMA previously testified (July 28) on the Greenberg case and the desperate need for ERISA reform. We also have asked the Solicitor General to request the Supreme Court to re-hear the case.

It is this crisis -- and our recognition that states are willing and able to act to remedy these problems -- that prompts this statement. The courts will not solve this problem. Only through legislation can these issues be addressed. The AMA commends the efforts of Sen. Patrick Leahy (D-VT), this Committee and other members of Congress to address the need for ERISA reform through legislation such as S. 3180.

We believe such reform is vital to the AMA's health reform vision proposed by our plan, Health Access America. Through HAA, the AMA recommends legislative initiatives that would ensure defined health care coverage for all Americans through an employer mandate. Our program, similar to a provision in S. 3180, seeks a uniform floor of essential benefits for all Americans -- through required employer-based private insurance and through government programs for those outside the employment setting. HAA also advocates the establishment of a level playing field where all plans -- insured and self-insured alike -- play by the same rules.

To that end, we strongly support amendment of ERISA that would allow states to involve self-insured plans in risk pools or other programs to provide for the uninsured. We also support legislation that would allow states to obtain waivers from the onerous effects of ERISA pre-emption in order to achieve state health care system reform.

The AMA is committed to working towards ERISA reform in light of ERISA's seriously negative implications for Health Access America, its effect of denying beneficiaries promised health care benefits with impunity, and its continuing blows to state health system reform. In that spirit, the AMA offers the following comments and recommendations regarding S. 3180 based on our three most significant ERISA-related policy concerns:

- the adverse effect of ERISA pre-emption on beneficiaries, as demonstrated by the Greenberg v. H & H Music Co. case;
- ERISA's block of state health system reform initiatives; and
- the AMA's current policy to allow states a range of creativity and to oppose state-mandated benefits packages.

ERISA Reform Related to Greenberg v. H & H Music Co.

State or federal reform legislation must contain provisions to remedy the bad faith and discriminatory practices now allowed by ERISA and upheld in cases such as Greenberg and Pilot Life. The AMA recommends that S. 3180 and other reform bills address this problem by allowing state regulation of all self-insured plans to permit state court actions and remedies to proceed against self-insured plans that engage in such practices. The AMA also suggests that ERISA be amended to provide deterrents to misconduct through substantive remedies, such as inclusion of awards of damages and attorneys fees to prevailing parties.

ERISA Reform Needed to Advance State Health Care System Reform

Innovative state health care reform proposals have been blocked and will continue to be impeded by ERISA pre-emption of any such state initiative that touches a self-insured health benefits program. The AMA supports state efforts to address the specific needs of each state's health care systems and constituencies. ERISA waiver legislation is absolutely essential to advance such efforts.

Recent ERISA court decisions, such as the United Wire case in New Jersey, have pre-empted a variety of state laws and financing plans aimed at reform, including attempts to: finance risk pools for the uninsured and those who are medically uninsurable by virtue of pre-existing health

conditions; offset indigent care costs for hospitals; and subject self-insured plans to self-reporting requirements.

State health reform efforts cannot advance without ERISA waiver legislation, as members of this Committee have recognized. The AMA supports these legislative efforts and recommends that any ERISA waiver legislation be broad-based enough to significantly address health care access problems in all states. Legislative reform efforts to meet this goal, such as Sen. Leahy's S. 3180, that would provide a grant program including ERISA waivers to a limit of 10 states, is an important first step.

The AMA is concerned that limiting the grant of state ERISA waivers will delay needed wide-ranging health care reform efforts. Legislation must be introduced to ensure that an administrative ERISA waiver application process, such as that now in place for Medicaid and Medicare requirements, is allowed. The essential premise of S. 3180 -- to develop such an administrative process -- is crucial to state health care reform. The AMA commends this idea and recommends that ERISA waivers be made available to any state requesting such a waiver on an ongoing basis. We also recommend that such waiver authority be constructed in a way to allow states the flexibility and creativity to develop their own unique health system reform models.

ERISA Reform to Provide Basic Essential Benefits, Not State Mandates

The AMA supports federal legislation that will facilitate an employer's provision of a uniform floor of essential benefits, and supports legislative efforts to advance such initiatives to protect beneficiaries, without the threat of pre-emption. We endorse the concept of allowing beneficiaries a reasonable choice of benefits packages, an idea we specifically supported in S. 1872, sponsored by Sen. Bentsen.

One key concern we would address related to the legislative establishment of a minimum floor of benefits is a provision in S. 3180 that would allow an exception to minimum state plan requirements in the event a self-insured plan offered a benefits package equivalent to at least $1,250 per individual and $2,500 per family. The language must be clarified to ensure that such self-insured plans cannot avoid the scope of state reform simply because they purport to provide actuarially "equivalent" benefits.

The AMA is concerned that this provision could allow self-insured plans to fashion their benefit packages -- in a manner contrary to the very concept of insurance and the intent of the bill -- by providing coverage for only inexpensive maintenance care and avoiding coverage for catastrophic or costly health events. This exception also could encourage self-insured plans to downgrade benefits to meet only the minimum standards.

While the AMA does support a federal policy to require a "basic" benefits package, we are opposed to a state mandate or even a federal mandate of state benefits in a "standard" benefits plan or its equivalent that goes beyond basic health care benefits. The AMA is sympathetic to the intent of legislation to establish a meaningful benefits package that will protect beneficiaries within state waiver plans. But we believe any reform legislation should encourage state creativity and experimentation. States should not be required to adopt, nor should the states mandate, a benefits package other than a basic or essential package, that has been determined by expert study to be both cost-effective and beneficial to our patients.

Conclusion

The AMA supports legislation to advance state health care reform efforts, and particularly recommends that legislation to allow all states to achieve waivers of ERISA through an administrative process be advanced immediately. Court decisions and other events of the past few years have demonstrated that state reform efforts will continue to be stymied by ERISA; legislation is needed now to give states the chance to do the work necessary to attain reform. Legislative remedies to end the current injustices in cases like Greenberg and Pilot Life that continue to be perpetuated by self-insured plans through ERISA also must be included as an essential component of ERISA reform.

We applaud the Committee, Senator Leahy, and other members of Congress for efforts to advance ERISA reform. We offer our expertise and interest in continuing to work to solve this major health care access problem in the future.

Statement of the Association of Private and Welfare Plants

I. Introduction

The Association of Private Pension and Welfare Plans (APPWP) is pleased to offer to the Members of the Committee on Finance our comments on the "State Care Act of 1992," (S.3180). The APPWP is deeply concerned about the prospect of eroding the preemption provisions of the Employee Retirement Income Security Act (ERISA). We are convinced that this proposed legislation would deeply wound the preemption protection, deliberately created by its authors to help promote greater private sector health care coverage, and lead to further efforts that would eviscerate ERISA's 18-year system of uniform national regulation. We recognize the good intentions of this bill's sponsors, and the frustration of this country's governors regarding health care reform, but we must forcefully oppose S. 3180 as ill-suited to fix a nationwide system breakdown.

The APPWP is a nonprofit organization whose members include large and small employee benefit plan sponsors and organizations providing support services to those plans. Our members directly sponsor or administer employee benefit plans such as pension and health benefit plans covering over 100 million Americans. All APPWP members provide health insurance for their employees, and most, but not all, are self-insured. APPWP members are thus keenly aware of the health care cost and access crisis confronting our nation. As a national trade association, the APPWP encourages a national debate on the issues of health care reform and seeks to join with others attempting to develop a comprehensive national strategy to tackle these difficult issues.

We recognize the states as "laboratories of democracy" and understand that for many compelling reasons they have begun implementing state-based health care reform in lieu of a national solution. While we understand the great pressures confronting states to address this crisis, we have reservations regarding this type of experimentation and fear it may lead to an unnecessarily complex, expensive and piece-meal approach to reforming the nation's health care system. We are convinced that this approach to reform may cause added uncertainty about the future direction of health care reform nationwide. The APPWP believes that the Federal Government should provide the forum for the national debate on health reform, and carefully and consciously weigh all interests, drive consensus, and implement reform policies.

Therefore, based on the our review of S. 3180, the APPWP must oppose this measure, despite the good intentions of its authors.

II. Erosion of ERISA Preemption and Taxation of Benefit Plans

Danger of Encroaching Mandates Evident

The APPWP is especially concerned with S. 3180's attempts to erode what one of the chief sponsor's of ERISA called its "crowning glory" - preemption. Clearly, the bill's narrowly-crafted ERISA waiver provisions are a direct attack on preemption. Sixty-percent of America's employers who offer health insurance to their employees are self-insured and enjoy the benefits and protection of ERISA preemption, as ERISA's authors wisely intended. Companies self-insure for several reasons. Many companies opt to self-insure to get out from under the more than 800 state-mandated benefits currently on the books across the nation. ERISA also permits employers the freedom and flexibility to design health plans that are most cost-effective and that meet the specific needs of their workforce. Finally, and most importantly, others self insure because they are multi-state companies who need the administrative uniformity provided under ERISA.

The experience of many employers with state mandates suggests that the basic benefits package prescribed under S. 3180 represents a slippery slope towards either mandating specific (and costly) benefits for all employers or, as another provision of the bill provides, allowing for the taxation of self-insured companies in order to pay for the health coverage for individuals who lack coverage.

We commend the authors of this bill for recognizing that most major employers are doing a good job of providing adequate-to-generous coverage for their workers and families; currently over 188 million Americans receive employer-provided coverage. S. 3180 would, therefore, not impose the bill's mandated benefits package on those self-insured plans that provide a certain basic level of benefits. The use of self-insurance is often an efficient and economic means of providing health benefits and frequently the only cost-effective way an employer is able to provide such benefits to its employees. Taxing such benefits will raise costs and therefore, discourage many employers from providing health benefits to their employees. A recent study by APPWP member company A. Foster Higgins found that not only did self-insured companies have lower per-employee costs than insured plans, but that they experience lower rates of increased costs as well. APPWP members generally offer very generous benefits packages and will likely not have problems complying with the specified level of contributions in S. 3180. Again, however, experience has taught us that such minimal benefit levels can be easily and quickly modified to require a level that is less affordable.

The APPWP is also concerned that this so-called "carve-out" for self-insured plans has not been fully thought through. The bill requires that a federal commission determine whether a self-insured employer's per-employee contribution to the health benefit plan is equivalent to the national average of at least $1,250 for individuals and $2,500 for families living in a demonstration project state. The language of the bill leaves vague and uncertain how this calculation will be made and how often it is to be determined; however we fear that this calculation will prove to be too complex and too subjective. Our concern is that employers will be required to make this calculation, possibly creating a situation similar to the horrendously complex and justifiably-repealed Section 89 requirement, which necessitated valuing different benefit offerings.

Finally and importantly, this bill seeks to allow states to pay for increased access to health care by taxing providers, insurers and self-insured companies. We object to any measure which would allow states to tax the voluntary health benefits offered by self-insured plans.

Taxing employers who provide coverage to pay for others who lack coverage makes employers pay twice. This is unfair.

If ERISA preemption is eroded, and employer-provided benefits are taxed, many more Americans may lose coverage or see diminished coverage. Employers will either lose the incentive to adopt new health plans, discontinue current health plans, increase wages in lieu of benefits, or offer cash substitutes as an alternative to providing health coverage to their employees. This bill will force employers to rethink their voluntary sponsorship of benefit plans. Constraining their flexibility will only serve to drive up the cost of these plans, exacerbating the current access to health care crisis.

III. Cost Containment Not Adequately Addressed

"State Care" does not adequately address the issue of cost containment and may have the effect of weakening more aggressive employer cost-saving efforts such as managed care. The high cost of health care, not ERISA, is the real culprit in our health care crisis. The bill seeks to solve the rising cost of health care by legislating states to set a global health budget, which would cap a state's total health outlays, both pubic and private. The proposal calls on demonstration states to produce a health care budget which will be a fixed percentage of the gross domestic product on health care expenditures; this number would be reduced over the course of several years. Containing the rising costs of health care is a much sought-after goal, but global health budgets will not really control the causes of rising prices or costs.

Global budgets have three fundamental flaws. First, no one can be sure of the correct amount of health care spending for a given state. If the cap is set too low, waiting lines and a reduction in the quality of health care would result. Of course, if the cap is set too high, it would not have the desired effect of containing spending. Second, assuming the right amount could be determined, allocating this number into the appropriate set of services and adjusted for variables such as geography, age, and provider-specific demand would be nearly impossible. Lastly, global budgets address the symptoms but not the causes of the health care crisis. Global budgets divert attention from the underlying reasons for rapid increases in health care such as the utilization of expensive technology and the high cost of provider services. Providers of health care have historically responded to these types of controls by increasing the volume of services delivered in order to maintain their profit levels.

S. 3180 does call for cost-saving measures such as ensuring that health care providers offer services consistent with practice guidelines developed by the Agency for Health Care Policy and Research (AHCPR). These guidelines may reduce some costs by standardizing certain medical procedures which have become routine and serve as a minimum standard of care, especially as a potential legal defense in liability actions against providers. However, to date, the AHCPR has published only three of these guidelines and may complete several more within the year. While the AHCPR has been efficient in completing its mandate, it is uncertain whether it would be able to finalize the universe of potential practice guidelines any time soon. It is impractical to expect their use as meaningful cost containment tools during the demonstration period.

IV. Are State Demonstrations Really Needed?

We also question the premise in S.3180 that further state experimentation is needed or that allowing the states to conduct demonstration projects can hold the answers for national reform at all. A recent report issued by the Employee Benefit Research Institute (EBRI) stated that the Medicaid program, a federal-state partnership for providing health care services to the poor, *is* "state experimentation at work." We are concerned that when the five-year demonstration period prescribed in S. 3180 ends, the conclusion that may be drawn, as many already have from the Medicaid experience, is that health care reform is complicated and expensive and that the American public is, in general, resistant to raising taxes to fully fund programs for the poor.

We believe that enactment of this proposal could complicate national reform efforts altogether. While the demonstration project states pursue their goals over five years, the future of health reform will be left uncertain.

It is possible that -- owing to variations of state plans by design and population -- after five years of experimentation we'd end up with projects which are non-transferable to the nation at large and therefore prove to be unworkable. Creating new high tax health care states would provide an incentive for some employers to move out of state. Certain individual states may not have a sufficient tax base to implement and sustain reform measures, and thus should never be allowed to go forward with reforms.

V. Establishment of National and State Commissions Redundant

While we are hereby on record against granting ERISA waivers, we would also wish to point out that this bill creates complex new layers of bureaucracy that would hinder government efficiency. One of the stated purposes of the proposal is to create a "one-stop-shop" waiver approval process regarding the regulatory and statutory requirements of Medicare, Medicaid and ERISA. Assuming *arguendo* that such waivers are needed, the logic in allowing states to apply for waivers in a single place is clear. However, the proposed circuitous process and multiple organizational obstacle course through which states must go to receive this waiver undermines all simplicity. If Congress feels compelled to move forward with this measure, we suggest, as a practical matter, that the Secretary of Health and Human Services and Secretary of Labor share responsibilities as they do currently under ERISA. As you know, this alternative, although not identical, is more in keeping with the original intent of the "State Care Act of 1991," (S. 1972).

VI. Conclusion

The APPWP must underscore its very strong objections to S. 3180. First, the APPWP objects to any erosion of the ERISA preemption, and S. 3180 would engender such erosion. Second, we oppose S. 3180 because this bill seeks to allow states to pay for increased access to health care by taxing providers, insurers and self-insured companies. Finally, S. 3180 does not adequately address the issue of cost-containment. Developing effective meaningful, and consistent health reform proposals for the nation are long over-due. Sending a signal to major employers providing benefits to millions of Americans, that ERISA's protection is in danger, is the wrong place to start. If Congress enacts this bill, the very problems it seeks to address--access to health care and cost containment--may grow worse and postpone for the nation the ultimate choices which must be made. We would welcome the opportunity to work with the bill's sponsors, and all others, concerned about expanding health care coverage, containing ever-rising costs, and reshaping employer-based system.

Statement of the U.S. Department of Health and Human Services

Thank you for the opportunity to submit our views on State health care reform issues considered by this Committee on September 9, 1992. Reforming our Nation's health care system continues to be a top priority for this Administration. Early this year the President proposed the Comprehensive Health Reform Program, a practical and comprehensive plan that would control costs, maintain quality and provider choice, and make health care more affordable and accessible. To assist Congress in considering our proposal, five pieces of that comprehensive plan have been drafted and sent to Congress.

A key objective of the President's proposal is to modernize the Medicaid program and offer States significant flexibility in forming a program to assure universal coverage for all poor people. We are particularly interested in alleviating the hurdles States now face as they try to improve the quality of health care by fostering greater access to coordinated care systems. To the many who take advantage of coordinated care systems, the continuity of care offered is substantially better than the hodgepodge of fragmented care often seen in fee-for-service medicine. For Medicaid recipients, coordinated care systems will offer enhanced access to the important preventive and primary care services frequently difficult to obtain in the traditional fee-for-service system.

Generally, we favor removing unnecessary obstacles that deter States from experimenting with innovative programs. However, we do not support S. 3180, the State Care Act of 1992, for the following reasons, including:

- a new, unneeded, and duplicative commission would be created to review and approve State project grant requests. The Commission would exercise authority currently and appropriately vested in the Executive Branch;
- excessive constraints would be placed on States' abilities to develop innovate reforms; and
- waivers of ERISA would be granted, increasing costs to businesses and individuals.

Specifically, S. 3180 would authorize a State-Based Comprehensive Health Care Commission to review and grant waivers to up to 10 States for purpose of State health care reform experimentation. The Commission, to be appointed by the President, could make grants to each of the qualifying States. The bill specifies criteria that States must meet to be eligible for the demonstration. The bill defines certain exemptions from the Medicare, Medicaid and ERISA statutes that States could request to carry out the demonstrations.

The State-Based Comprehensive Health Care Commission conceived by the bill would replace the existing authorities now in place to approve, monitor and evaluate demonstration projects. In addition to the Secretaries of HHS and Labor, the Commission would include 11 other members who were not previously part of the Executive Branch. Adding a Commission, regardless of its composition, is inappropriate, unnecessary, and adds to the further layering of the bureaucracy.

The extensive authority given to the Commission in S. 3180 is clearly inappropriate. We believe the authority to waive statutory provisions of a law and to monitor and evaluate initiatives that experiment with a law should rest with the appropriate authority in the Executive Branch charged with administering that law.

The bill is highly directive with regard to the State's organizational approach and required benefit package. We support the right of States to each determine, in the context of its own unique environment, its own approach to defining and/or requiring a minimum benefit package without significant Federal intervention. Further, the bill seems to contemplate a limited range of health care reform concepts with which States could experiment and seems most conducive to supporting "play or pay" schemes.

The amendments to the Employee Retirement and Income Security Act of 1974 (ERISA) would grant States the authority to tax self-insured organizations for purposes of helping to fund care for the uninsured. ERISA generally supersedes State laws regulating employee benefit plans, including those providing health benefits. ERISA preserves the right of States to regulate insurance, although employers who are self insured are not subject to such regulation. While we generally defer to the Department of Labor on issues related to ERISA, we are greatly concerned about increasing the financial burden on today's businesses which this bill clearly would do. We also question whether granting exemptions to this statute may eventually lead to imposing State-mandated benefits on self-insured entities.

In summary, we cannot support this bill because of the serious concerns addressed above. The Administration has stated in a recent letter to Senators Bentsen and Durenberger its interest in removing unnecessary obstacles that deter States from experiments with innovative programs. We wish to confirm that interest here. We do not, however, believe this is the vehicle.

Statement of the VITAS Healthcare Corporation

VITAS Healthcare Corporation ("VITAS") operates nine comprehensive inpatient and home care hospice programs in Florida, Illinois and Texas, including a specialized hospice service for AIDS patients. Our organization is the largest provider of hospice services in the United States. Everyday we care for more than 2,000 persons. In addition, we provide bereavement counseling to thousands of family members. VITAS provides services directly through its own staff of approximately 1,350 employees and hundreds more unpaid volunteers, as well as through affiliations with leading hospitals, health maintenance organizations, physician groups, and nursing homes. VITAS's purpose is to provide the highest comprehensive and carefully managed services and products of the highest quality to terminally ill patients and their families.

Hospice is not a place or a concept. It is a health care provider defined by Medicare and by many state laws that takes complete clinical and financial responsibility for delivering to terminally ill patients and their families the full range of palliative care services they need -- including psycho-social support services -- to live their final months with comfort and dignity. As such, hospice substitutes for other health care entities that are designed to provide curative therapy to patients, which therapies will no longer benefit our patients. Hospice differs from most health care enterprises in that it is not defined around a limited set of services, such as acute care or skilled nursing, but by the needs of its patients. Thus, hospices are authorized by Medicare, Medicaid and most state laws to deliver whatever services are needed by the terminally ill patient, in whatever setting is appropriate.

While hospice care was born out of compassion and a need to treat terminally ill patients and their families in a more appropriate, humane fashion, I believe it has proven to be a paradigm for providing higher quality, better managed care, at lower costs, to patients who are catastrophically and chronically ill. These patients require a broad range of services delivered in various settings, and therefore would benefit if those services were effectively coordinated according to a single plan of care by a single provider that would take full clinical and financial accountability for all of the services and products delivered to the patients. Thus, the hospice modal of managed care is not only applicable to the terminally ill, but also to other categories such as neonatal patients, trauma and rehabilitation patients.

Hospice truly is a model for better managed health care, both in terms of quality of care, quality of life, efficiency of health care delivery and cost containment. Hospice reduces expensive and often traumatic and unnecessary hospitalizations while improving clinical outcomes and the quality of life. Because hospice delivers a comprehensive package of services, and is solely responsible for those services, it improves the efficiency and accountability of health care delivered to its patients. Thus, with respect to the patients whom hospice serves, the terminally ill, hospice addresses the two key health care problems facing our nation today: affordability of care and access to care.

Hospice is also contributing to the improved quality of life and cost of service to our patients by addressing difficult ethical dilemmas that curative treatment-oriented providers have faced when the patient becomes incurable. Unfortunately, in this country, our cultural and social values have worked to keep incurable patients alive at tremendous costs for long periods of time regardless of the declining -- often horrible -- quality of life this type of health care achieves. Our health care system too often provides incentives to use the newest, most expensive technology even when there is virtually no medical justification or need. It was not so

long ago when the typical terminally ill patient routinely suffered through painful invasive procedures and repeated hospitalizations regardless of prognosis. Or, worse yet, incurable patients often were simply abandoned by the provider. Stories of cancer patients receiving amputations, chemotherapy or other costly, painful procedures on the day before death were the norm. Families had no role. Sadly, this experience is still the reality for the many patients not referred to hospice. By avoiding the unnecessary and inappropriate use of expensive high tech procedures and repeated acute care hospitalizations, hospice provides a model of managed care.

The essence of hospice's ability to be effective in clinical management and cost control is the interdisciplinary team working to implement a formal plan of care that addresses all of the patient's needs. Managed by a Team Director, the interdisciplinary team consists of physicians, nurses, aides, counselors and social workers, chaplains and volunteers. These teams work with the patient, the family and the attending physician. They provide, either directly or through closely supervised subcontractors, all of the nursing, physician, counseling, social work and home health aide services needed, as well as medications, supplies and therapies related to a patient's terminal illness. These services and supplies are delivered wherever the patient is treated, whether at home or in a hospice inpatient setting. Hospices accept full clinical and financial responsibility for all the care and services related to the patient's terminal illness, except the services of the patient's personal physician. This assures continuity of care, efficient integration of the many services needed, and accountability. This hospice is reimbursed with an all inclusive per diem rate. There is no other payment to any other provider with respect to the patient's terminal illness, except to the patient's attending physician.

Since the hospice maintains total professional management responsibility for the care, patients look to one health care provider to be responsible for the quality of all services. This also allows the hospice an opportunity to have a total understanding of the patient and family needs, as well as the ability to control costs.

While hospice care is viewed as a substitute for hospitalization, it is that and more -- hospice differs from traditional curative medical care in many ways. The hospice Medicare/Medicaid benefit focuses on the patient's needs and not the provider's. In addition to treating the patient's physical needs, hospice care provides emotional and other support to both the patient and the family. This includes bereavement counseling to family members. Hospice encourages family members to actively participate in patient care rather than to be wholly dependent on health care professionals. The hospice benefit is the only Medicare/Medicaid benefit which requires that a patient waive other benefits, such as hospitalization. It is reimbursed on a fixed, per diem basis. In addition, hospices are the only providers required by law to use volunteers. In fact, volunteers must provide 5% of total hours of patient care activities. This requirement grew from congressional concern for the continued commitment to the use of volunteers.

Hospice understands and treats the needs of terminally ill patients. These patients suffer terribly from symptoms associated with end-stage diseases such as cancer and AIDS. Pain is the most frequent presenting symptom, seriously affecting approximately 78% of the patients for whom VITAS provides care. With all the medical advances and new technologies of the last decades, pain is still often ineffectively treated among terminal patients. The clinical studies conducted within our organization have demonstrated that our hospice care has served to reduce pain demonstrably in nine out of ten cases.

Physical outcomes are but one result. Emotion is also a factor in all illness, especially chronic illness, and most especially in terminal illness. Physical prognosis can vary greatly depending on the patient's emotional status. Hospice specifically and successfully addresses the difficulties of emotional distress. Virtually every study on the desires of terminal patients indicates that these patients prefer to be at home. They do not want to remain in acute care hospitals. Most all hospice patients achieve this desire and are able to return home.

Physical and emotional consequences are not the only ones to be considered in developing a program of managed care for terminal patients. Cost containment is another principal goal. Hospice achieves superior financial outcomes in several ways. As discussed, it is an efficient way to organize services. It provides a sole point of accountability for those services. Moreover, hospice care is an explicit substitute for other benefits. This is a key to the concept of hospice and its cost containment potential. As previously mentioned, hospices receive an all inclusive per diem for which the hospice must provide and manage all of the care and services, at home or in inpatient facilities, related to the terminal illness. Under the Medicare or Medicaid system, patients desiring hospice care must make a conscious choice to waive their eligibility for all other health care benefits relating to their terminal illness. Having made this choice, patients receive better and more appropriate clinical management, yet avoid the costly hospitalization and "heroic" interventions that so typically and needlessly burden the last days of the incurable patient who has not chosen hospice.

Although hospice is primarily care at home, some patients' pain or other symptoms require care management in inpatient settings. VITAS operates its own inpatient facilities which are designed in a home-like comfortable manner. These facilities allow families to stay overnight and have no visiting restrictions. Families are encouraged to participate in patient care. While these inpatient units have intensive staffing, costs are contained and managed by the fixed per diem reimbursement and by a limit on the number of inpatient days under the Medicare/Medicaid system.

The costs associated with caring for terminal patients through non-hospice traditional health care are stunning. The Health Care Financing Administration ("HCFA") has reported that persons in their last 180 days of life account for nearly one-fourth of all outlays from the Medicare program and more than one-fourth of all Medicare-paid hospital days. HCFA studies have indicated that, without hospice care, a patient in the last 60 days of life is hospitalized an average of 21 days. At $1,000.00 a day, which is a conservative figure, this is a per patient cost of $21,000.00 in hospital care alone. And, the overwhelming majority of these patients die in acute care hospital beds.

In hospice, the results are reversed. The vast majority of hospice patients die at home. In fact, in our Dade and Broward programs, the typical hospice patient spends only about 8.5 days in inpatient settings during the last 60 days of life. The Medicare/Medicaid hospice model explicitly limits the number of inpatient days for which a hospice program can be reimbursed at the inpatient per diem rate to 20% of total patient care days. Our experience has shown actual inpatient hospice care accounts for less than 10% of total patient care days.

In return for accepting full clinical and financial responsibility for all care and services related to a terminally ill patient's care, hospices receive only about $6,500.00 in reimbursement for the typical patient. Outside the hospice system, the costs for terminally ill patients multiply dramatically. In addition, the current Medicare/Medicaid hospice benefit imposes a

cap on hospice costs. To date, actual per patient outlays have been far less than the cap amount. Because hospice costs are capped and hospices provide comprehensive services at home and in nursing homes, hospice care costs much less than conventional hospital-intensive care. Without the hospice benefit, terminally ill patients would be forced to choose conventional, costly hospital-based care.

Hospice also offers innovative methods of caring for patients with AIDS and other complex and costly diseases. In response to the need to make hospice care available and accessible for people with AIDS, VITAS created a separate service called the "Outreach Program". In its Outreach Program, VITAS has cared for over 2,000 people with AIDS. The hospice benefit as originally developed under Medicare was designed for the elderly cancer patient with a fairly predictable progressive disease process. Accordingly, the Medicare/Medicaid benefit does not completely fit the clinical aspects and other needs of most AIDS patients. Palliative home care is accomplished through more high tech forms of care -- more high tech forms required to avoid repetitive hospitalization of these patients. The Outreach Program combines these high tech forms of home care with a more intensively staffed psycho-social program that is multicultural and stigma sensitive. Inpatient services are also made available. The result has been to break the cycle of expensive hospitalizations and significantly reduce costs by holding the provider responsible for the vast array of service needs. Our experience has been very instructive. Our program has served up to 40% of all those dying of the AIDS virus in Dade county. Participation in our hospice Outreach Program is approximately 3 months, and those who die while under our care access the acute care setting fewer times and for less duration than those under traditional care. With limited expert clinical resources available to these clients in most communities, access to hospice care provides professionally managed care that deemphasizes acute care and institutionalization for purely academic concerns and offers these patients sensitive and clinically competent services in their home environment.

By investing in a more intensive level of hospice care for AIDS patients, Congress would obtain a less expensive substitute system for hospital-based care.

Much can be learned from hospice care about cost containment and innovative approaches for treating a variety of patients. The clinical, financial and patient/family satisfaction results that hospice programs have achieved should be integrated as a basic benefit into a national health care reform package. Hospice care is a clear example of innovative health care that has moved away from expensive institutionalized care and has simultaneously resulted in improved clinical outcomes and quality of life for the patient, as well as cost savings. S. 3180 should include the hospice benefit developed under the Medicare system as a basic and a standard benefit, which would allow all terminally ill persons to choose hospice care as a substitution for, and an alternative to hospitalization, as well as other benefits related to the terminal illness.

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